# Health Law PA News

Newsletters of the Pennsylvania Health Law Project
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## New Medicare Durable Medical Equipment and Supplies Program To Begin in SW Pennsylvania

Medicare will start a new Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program **on January 1, 2011** in certain regions of the country. One of those regions is the Pittsburgh Competitive Bidding Area which consists of Allegheny, Armstrong, Beaver, Butler, Fayette, Washington and Westmoreland counties along with small sections of Clarion, Greene, Indiana, Lawrence, and Venango counties. Whether a consumer lives in the Pittsburgh Competitive Bidding Area depends on their zip code and can be determined by calling 1-800-MEDICARE or by going to www.dmecompetitivebid.com/palmetto/CBIC.nsf/DocsCat/Home.

The DMEPOS Program will change how beneficiaries in ***Original Medicare*** obtain their durable medical equipment and supplies. Consumers in Original Medicare are those that use their red, white and blue Medicare card to receive health care and treatment. Currently, if those consumers need any durable medical equipment or supplies, they can go to any provider or supplier who accepts Medicare. Under DMEPOS however, consumers must use a contract supplier that has been chosen by Medicare through a competitive bidding process. Medicare announced the DMEPOS contract suppliers in early November. Contracts were awarded to providers offering a low price and meeting certain other criteria. The list of contract suppliers by region can be found at www.cms.hhs.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp.

*Beneficiaries enrolled in Medicare Advantage Plans are not affected by DMEPOS and can continue to use any suppliers authorized by their Plan.*

DMEPOS will affect Medicare beneficiaries who have Original Medicare and who permanently reside in a zip code included in the Pittsburgh Metropolitan Area, or who are visiting the Pittsburgh Metropolitan Area and who need an item covered by DMEPOS. In most cases, beginning January 1, these Medicare beneficiaries will only be able to use contract suppliers to obtain the following items covered by DMEPOS:

- Oxygen, oxygen equipment & supplies
- Standard power wheelchairs and scooters
- Complex rehabilitative power chairs and accessories (group 2)
- Mail-order diabetic supplies
- Enteral nutrients, equipment & supplies

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- Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs)
- Hospital beds and related accessories
- Walkers and related accessories

Note that there is a process in place to allow consumers to continue to use current non-contract suppliers. However, this exceptions process is only available to consumers who are renting durable medical equipment before January 1, 2011 and whose non-contract supplier elects to be "grandfathered" by Medicare. Medicare will be mailing out a letter and a brochure to all Medicare beneficiaries in the Competitive Bidding Areas that explains the DMEPOS program. Suppliers that are currently serving Original Medicare beneficiaries are responsible for notifying their customers whether they will be a contract supplier under DMEPOS and, if not, whether or not they will elect to be "grandfathered".

Anyone having questions or concerns about the DMEPOS program can contact PHLP's Helpline at 1-800-274-3258.

# MA Recipients Having Problems Getting Maternity Care in Norristown

Pregnant women on Medical Assistance living in and around Norristown, Pennsylvania – the county seat of Montgomery County – are having a hard time obtaining prenatal appointments in a timely manner. The only prenatal care site in Norristown that accepts Medical Assistance patients has an average wait time for an initial prenatal care appointment of 11.5 weeks. Typically, women with commercial insurance can get an appointment in 2.6 weeks. Access to prenatal care in Norristown for Medical Assistance consumers had been difficult for several years, but worsened this year after Mercy Suburban Hospital closed its obstetrics unit, leaving only Montgomery Hospital to provide care for the 1500 annual deliveries in the area.

Network access standards for Medial Assistance Managed Care in Pennsylvania require that a woman in her first trimester be able to be seen within ten business days of knowing she is pregnant. The contracts between the Department of Public Welfare and the Medical Assistance Managed Care Organizations also require that the managed care plan must have at least two obstetricians who are accepting new patients within a travel time of 30 minutes in an urban area. At the present time, there are no other obstetricians accepting Medical Assistance women who are within 30 minutes travel time of Norristown.

The Consumer Subcommittee of the state's Medical Assistance Advisory Committee and the Maternity Care Coalition of Philadelphia have both been meeting with Department of Public Welfare officials in an effort to remedy the situation. If women on Medical Assistance are experiencing similar problems accessing prenatal care in other parts of Pennsylvania, they should contact PHLP's Helpline at 1-800-274-3258.


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# New Enrollment Broker Started December 1st for Certain Home and Community-Based Services Programs

As of December 1, 2010, MAXIMUS will be performing intake and enrollment services across Pennsylvania for the following programs: **AIDS Waiver; Act 150 Attendant Care Program; Attendant Care Waiver; COMMCARE Waiver; Independence Waiver; and OBRA Waiver**. The Pennsylvania Office of Long-Term Living (OLTL) recently selected MAXIMUS as the Independent Enrollment Broker for these programs following a competitive bidding process. Up until now, the enrollment and intake process for each program varied widely depending on which program an individual was trying to access, the applicant's county of residence, and whether the applicant was living at home or in an institution. The state's goals for using an Independent Enrollment Broker are to simplify and improve the eligibility and enrollment process and hopefully make it easier for consumers and their family members to navigate the system.

MAXIMUS's responsibilities include:

- Providing education, outreach, and community awareness;
- Establishing a toll free line (1-877-550-4227) to respond to inquiries, screen consumers, and schedule in-home intake visits;
- Conducting initial intake visits;
- Facilitating the overall waiver eligibility determination process (e.g., securing physician documentation);
- Ensuring consumers select Service Coordination Providers;
- Transferring the individual and all necessary documentation, once they have been approved, to the enrollee's chosen Service Coordination Provider; and
- Notifying consumers of whether or not they are eligible for any of the programs as well as informing them of their appeal rights.

Applications for the above programs that were in process on December 1, 2010 will continue to be managed by the previous enrolling agency. MAXIMUS is responsible for all new applications initiated on or after December 1. Please note that currently, the COMMCARE and OBRA Waivers are not accepting new applicants.

For more information, or to be assessed for help with in-home support services through one of the programs listed above, consumers should call MAXIMUS at 1-877-550-4227.

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# Medicare Annual Open Enrollment Period Ends 12/31/2010—All Medicare Beneficiaries Should Review their Current Plan and 2011 Plan Choices

This is a reminder that all Medicare beneficiaries have until 12/31/2010 to change their Medicare Advantage and/or Part D plan for 2011. All individuals on Medicare should review their current plan to see if it will continue to cover their drugs and continue to be affordable next year. Individuals enrolled in Medicare Advantage Plans should also check to be sure their providers are still in the plan's network next year.

In 2011, there are 38 prescription drug plans available to consumers across Pennsylvania; 12 of these will be zero-premium for people with the full low-income subsidy (see p. 5 for information on new eligibility requirements for the low income subsidy). The list of 2011 zero-premium plans is now available on PHLP's website (www.phlp.org). Every county has many Medicare Advantage Plan options in 2011; beneficiaries in Fulton County have the fewest Medicare Advantage plan choices (12 plans), while those living in Lancaster County have the most options (40 plans). Most counties have between 20-40 plans available to people on Medicare. All but 9 counties (Bradford, Centre, Chester, Fulton, Franklin, Pike, Potter, Tioga, and Wayne) have at least one Special Needs Plan (SNP) available for people with both Medicare and Medicaid in 2011. Individuals can learn more about 2011 Medicare plan choices by visiting www.medicare.gov, reviewing the *Medicare & You 2011* Handbook, or calling 1-800-MEDICARE (1-800-633-4227). Individuals can also contact the APPRISE program for assistance with their 2011 Medicare plan options by calling 1-800-783-7067. Please see our ***October Senior Health News*** (available on our website) for more information about Medicare 2011.

This year, it is especially important to review plan choices for the upcoming year because of the elimination of the Medicare Advantage Open Enrollment Period (that had been Jan 1st-Mar 31st of each year in the past). Instead, there will be a new Medicare Advantage Annual Disenrollment Period (ADP) that will run from January 1st through February 14th of each year. During that period, anyone in a Medicare Advantage plan can disenroll from that Plan and go back to Original Medicare. Individuals who take advantage of the ADP to disenroll from a Medicare Advantage plan that includes Part D prescription drug coverage will get a Special Enrollment Period allowing them to enroll in a stand-alone Prescription Drug Plan. Individuals cannot change Medicare Advantage Plans or enroll into a Medicare Advantage Plan during this ADP; they can only use the ADP to disenroll from a Medicare Advantage Plan and go to Original Medicare.

**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.**


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# Slight Increase to Asset Limits for LIS and MSP in 2011

Effective January 1, 2011, the asset limits someone must meet to qualify for the Part D Low-Income Subsidy (LIS) and the Medicare Savings Programs (MSP) are increasing. The Part D LIS helps with Medicare Part D costs by eliminating the donut hole, reducing co-pays, and helping with the annual deductible and monthly premium costs. The MSP provides coverage of the Medicare Part B premium and may help with Medicare Parts A and B cost-sharing for qualified individuals. Individuals apply for the LIS through the Social Security Administration and apply for the MSP through the PA Department of Public Welfare.

***Part D Low-Income Subsidy (LIS)***
The LIS asset limits in 2011 will be:

- **Full Subsidy-$6,680 for a single person and $10,020 for a married couple** (these limits are currently $6,600/single person and $9,910/married couple)

- **Partial Subsidy-$11,140 for a single person and $22,260 for a married couple** (these limits are currently $11,010/single person and $22,010 married couple)

In addition to the asset limits, there are income limits as well. Individuals must have income below 135% FPL (currently $1,218/mo for a single person and $1,640/mo for a married couple) to qualify for a full subsidy and below 150% FPL (currently $1,354/mo for a single person and $1,821/mo for a married couple) to qualify for a partial subsidy. These income figures will remain in place until any adjustment to the FPLs for 2011 (which usually occurs in February of each year).

Please note that the amounts shown above are what someone must meet *after* all deductions and disregards are taken (including the $1500 per person disregard the Social Security Administration gives if someone plans to use their assets for funeral and/or burial expenses)

***Medicare Savings Programs (MSP)***
Since January 1, 2010, federal law requires the MSP asset limits to match the asset limits for the full Low-Income Subsidy . Therefore, **in 2011, the MSP asset limits will be $6,680 for a single person and $10,020 for a married couple**. Again, these amounts are after all deductions and disregards are taken. The current MSP asset limits are $6,600 (single) and $9,910 (married couple). In addition to the asset limit, income must be below 135% FPL to qualify for the MSP (see the note above regarding FPLs).

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


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# Pennsylvania Officials and Stakeholders Meet Monthly About Implementing Health Reform

In May 2010, Governor Rendell issued an Executive Order creating a new Health Care Reform Advisory Committee (Advisory Committee) comprised of cabinet-level officials from health and human services agencies, members of the General Assembly, representatives of hospitals, medical professionals, group health insurance purchasers, budget and health policy experts, advocates, and two consumers. The Advisory Committee meets monthly to advise cabinet level officials about the implementation of the Affordable Care Act (ACA). In September 2010, the Advisory Committee created three subcommittees: Enrollment and Access, Exchange, and Other Critical Reforms, to develop recommendations in those subject areas. Since October, each subcommittee has met monthly prior to the full meeting of the Advisory Committee. Meetings have been coordinated by the Governor's Office of Health Care Reform.

The full Advisory Committee and its three subcommittees met November 17th. PHLP was appointed to the Advisory Committee and joined all three of its subcommittees. In this article, we highlight several significant issues impacting low income stakeholders raised by the Enrollment and Access Subcommittee:

The Enrollment and Access Subcommittee reacted to several presentations from the Department of Public Welfare and the Department of Aging on a variety of topics including Medicaid Expansion, Comparison of Essential Benefits, Basic Health Plan, and Options for Long Term Care. Handouts from each of these presentations are available and can be downloaded from the website of the Governor's Office of Health Care Reform (http://www.ohcr.state.pa.us/implementation/index.htm).

The Medicaid expansion estimates are noteworthy. In October 2010, Medical Assistance currently provided health coverage for 2.236 million Pennsylvanians, 17.8% of the population of the state. An additional 43,373 low income adults got health care coverage through the adultBasic program, and 192,623 children were covered by the CHIP program. Altogether, about one- fifth of the state's citizens currently have federal or state funded health insurance. Federal health care reform is expected to expand Medicaid coverage to an estimated 487,000 new recipients in 2014: 97,000 individuals who are currently eligible for existing programs but are not enrolled; 245,375 individuals on the adultBasic waiting list; 8,817 young adults who have aged out of foster care; 135,917 currently uninsured. Additionally, 104,224 individuals receiving Medicaid in the General Assistance category and 26,912 getting adultBasic (both of which are paid for using State funds only) will qualify for Medicaid under categories that will allow the state to get federal reimbursement.

**Subcommittee Recommendations:**

- Simplify Eligibility: By broadening the population eligible for Medicaid, the ACA provides an opportunity to greatly simplify the eligibility requirements for Medical Assistance. The Commonwealth should identify existing policies and rules governing CHIP and Medicaid that add unnecessary complexity and recommend changes that simplify the eligibility process.

- Determine Mechanisms for Enrollment: The Commonwealth should decide whether it is feasible and cost effective to build on its present technology for determining whether individuals will be eligible for a premium tax credit , cost sharing reduction, or other options in the Exchange, or whether it needs to develop new technology.

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The Commonwealth should identify obstacles to integrating the state's health insurance pro grams and develop a plan for making changes needed, including recommended changes to the Public Welfare Code.

- Revisit Benefits Package: Currently, there are 14 different benefit packages in the Medicaid program. Childless adults on Medicaid generally have very limited coverage for prescription drugs and dental care. Because Medicaid coverage for the expansion group of low income adults will include prescription drugs, the state should consider adding this benefit for the lower income adults already on Medicaid as a matter of equity. Pennsylvania may also wish to consider whether dental care should be offered to all individuals covered by Medicaid.

- Explore Continuity of Care: Currently, families with children receiving health care coverage through CHIP or Medicaid, have difficulty maintaining continuity of care when household income changes or when the child has a birthday which results in them switching from Medicaid to CHIP, or vice versa. This is because CHIP and Medicaid do not have the same provider networks in many instances. When eligibility for public insurance changes in any direction, families and individuals should not have to change providers during a course of treatment, especially those with incomes below 200% of the federal poverty level. Medicaid plans should have partnerships with non-Medicaid plans that offer access to the same provider network. The Commonwealth should explore a new approach that allows for continued relationships with care providers through eligibility changes.

The next meeting of the Advisory Committee is Tuesday, December 14th at the Pennsylvania Housing and Finance Authority Building, 211 North Front Street in Harrisburg. The subcommittees will meet consecutively beginning at 9:30 am. The full Advisory Committee will meet at 2 pm. All meetings are open to the public.

# Happy Holidays from PHLP!

As the year ends, we take a moment to wish all our readers happy and safe holidays and a healthy new year! PHLP is a small non-profit 501(c)(3) law firm. We encourage you to consider us when you are making any year-end contributions to charitable organizations.

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# adultBasic's Future In Jeopardy

The future of the adultBasic program continues to be uncertain. AdultBasic provides affordable, basic health coverage (no prescription drug coverage and no mental health coverage) at minimal cost (i.e., $36 per month) to over 40,000 Pennsylvanians with limited income, many of whom are working. An additional 3,600 individuals currently on the waiting list pay the full price ($629 per month) for the adultBasic coverage. Over 460,000 individuals are on the program's waiting list for subsidized coverage who are not able to afford buying into the coverage at full price. As we reported in our May 2010 newsletter, funding for the program was to expire at the end of this year. The four Blue Cross/Blue Shield plans in Pennsylvania have agreed to extend funding until June 2011. However, the current Administration recently announced that the contributions by the Blues aren't enough to sustain the program beyond early 2011. The program is underfunded by $54 million in FY 2010-2011 because money from the Tobacco Settlement used to fund the program was significantly cut from $37.8 million in FY 2009-2010 to $10.8 million this fiscal year, and because of disputed payments from Highmark and Independence Blue Cross (two of the four Blue Cross/Blue Shield Plans in PA).

Recent legislative attempts to secure funding for the program until 2014, when health care expansion reforms required by the Affordable Care Act are implemented, have failed. Advocates continue to press lawmakers to address the adultBasic funding crisis and will urge the new Administration to find longer term solutions so this program can continue to operate.

Should the adultBasic program terminate in early 2011, the program's 40,000+ members have to be notified prior to the termination becoming effective per contractual requirements. Although adultBasic offers limited coverage and doesn't come close to meeting the needs of the hundreds of thousands uninsured Pennsylvanians, its elimination will be a significant blow to PA's safety net for vulnerable individuals. Many adultBasic members are working, have no coverage available through their jobs, can't qualify for Medicaid and can't afford, or couldn't get, other health care coverage through the private market.

Individuals who are interested in taking action to help save adultBasic should visit the Pennsylvania Health Access Network's website, www.pahealthaccess.org, for ways to help in advocacy efforts.

# Gateway Health Plan Terminates Its Contract with Armstrong County Memorial Hospital

Medicaid managed care contract terminations continue to be a problem across the state and are now impacting consumers and providers in southwestern Pennsylvania. Effective December 31st, the contract between Armstrong County Memorial Hospital (ACMH) and Gateway Health Plan will end. This contract termination affects 6,230 Medicaid recipients who are members of Gateway Health Plan and who have received services at ACMH in the last 12 months. Of the affected members, 5,500 are currently assigned to Primary Care Providers who only have admitting privileges at ACMH. In order to continue seeing their current PCPs, these individuals will have to switch health plans. UPMC for You is the only other Medicaid managed care plan in southwestern Pennsylvania with a contract with ACMH. Individuals who do not wish to switch their health plan will need to contact Gateway by December 17th to pick a new PCP. Gateway members who have not acted to change their PCP or their health plan by that date will be auto-assigned to a new PCP within Gateway Health Plan's network.

Gateway Health Plan sent a letter notifying affected members about this contract termination

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in mid-November. The notice informs members about the contract termination and explains member's options. Continuity of care requirements in the HealthChoices contract protects plan members affected by a contract termination who are in the middle of a treatment plan. These plan members have the right to continue with their doctor and their course of treatment for at least 60 days after the contract termination. For pregnant members who are within six months of their due date, continuity of care provisions require the plan to allow the member to stay with her current doctors for the duration of her pregnancy.

***Please note that this contract termination only affects Medicaid recipients enrolled in Gateway Health Plan. It does not impact members of Gateway Medicare Assured.***

# Members of Keystone Mercy and AmeriHealth Mercy Health Plans Impacted by Security Breach

On October 19, 2010, Keystone Mercy Health Plan (KMHP) and AmeriHealth Mercy Health Plan (AmeriHealth), two Medicaid managed care plans operating in southeastern Pennsylvania, announced they had lost a computer flash drive containing the names, addresses, and some health information of 285,691 of their members. Included in this information were the full Social Security numbers of seven members as well as the last four digits of the Social Security numbers of 801 members. The information was intended for use at a community health fair. The data was not encrypted or otherwise protected.

KMHP and AmeriHealth sent letters to their members about the security breach. However, *The Philadelphia Inquirer* published a story about the missing information before the letters were sent to affected members. For those members whose Social Security numbers were on the lost flash drive, the plans will pay for a year's monitoring of their credit and identity. KMHP also established a toll-free telephone number to respond to questions from members about security concerns (**1-877-412-7145**).

Plan representatives acknowledged that they learned of the missing flash drive on September 20, 2010. They believed the drive was lost in their corporate offices, and thus delayed reporting the loss. The contract between the Medicaid managed care plans and the Department of Public Welfare (DPW) require reporting within five days. When they were unable to locate the drive, they reported the loss to the Department of Public Welfare, as required by HIPAA (Health Insurance Portability and Accountability Act) and their contract with DPW. The information on the drive included plan identification numbers for members, phone numbers, and records indicating when the member had received recommended health screening such as a mammograms or Pap smears. A small percentage of records – approximately 2200 – also contained member names. Privacy advocates maintain that this information should never be taken to public events, such as health fairs, both because of the risk of the information becoming public, and because the plan's employees are not qualified to order medical tests or discuss a medical condition with a member at those events. In *The Philadelphia Inquirer*, however, the Keystone Mercy vice president for communications stated that having this information available at health fairs was "vital to saving lives."

KMHP and AmeriHealth stated they were in the process of developing a way to encrypt member information. DPW announced they were looking at all the HealthChoices plans to review the security and uses of protected health information as a result of this problem.


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# AmeriChoice and Unison Merge

Two Medicaid managed care plans – AmeriChoice by UnitedHealthCare (United) and Unison Health Plan (Unison) – are finalizing a merger that took place earlier this year when United purchased Unison. Effective January 1, 2011, the new plan, ***UnitedHealthCare Community Plan***, will operate in all three HealthChoices zones and in many Voluntary Managed Care counties.

Current AmeriChoice and Unison members will receive new member ID cards, which they must begin using on January 1, 2011. These individuals will also receive new member handbooks that will detail changes to their benefits. For example, all members will use March Vision Care for their vision services. Additionally, members can expect some changes to their co-pays. United anticipates that all current AmeriChoice and Unison members will be able to continue seeing their current providers.

For more information about UnitedHealthCare Community Plan, individuals should call PA Enrollment Services 1-800-440-3989. Please contact the PA Health Law Project Helpline (1-800-274-3258) if a UnitedHealthCare Community Plan member has problems accessing services after January 1st.

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