SENIOR HEALTH NEWS

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DPW Going Ahead With MATP Mileage Reimbursement Reduction

We noted in our combined Newsletter for June/July 2011 that DPW was looking to make cost-saving changes to the Medical Assistance Transportation Program (MATP) beginning this Fall. PHLP recently learned that DPW has decided to delay implementation of a $2 co-pay for each one way shared ride or taxi trip provided by MATP while it works out issues and problems related to that change. In the meantime, however, DPW **is** going ahead with reducing the mileage reimbursement paid to MATP consumers who use their own vehicle (or someone else's) to get to and from their medical appointments.

In early September, the county MATP programs will be mailing 30 day advance written notices of this change to all consumers registered with MATP. The notice informs the consumer that the mileage reimbursement rate will be reduced to 12 cents per mile, plus parking and tolls. According to the latest information PHLP has been given, the change will go into effect on October 15, 2011. DPW estimates it will save $5.8 million by implementing this change as it works to address a $26 million cut to the MATP budget in the 2011-12 fiscal year.

This significant change could create a hardship for many MATP consumers. Up until now, every county MATP could determine its own mileage reimbursement rate. The lowest rate was 25 cents per mile, while some counties paid over 40 cents per mile. If, as a result of this mileage reduction, a consumer no longer has a vehicle available to get to medical appointments (for example, her neighbor has been driving her to appointments but is no longer willing to do so for only 12 cents a mile), the consumer can request to change their MATP service (to a bus pass, shared ride, taxi, etc). The county is responsible to provide a consumer with the least costly, most appropriate transportation available to meet the consumer's needs. If the county denies the consumer's request for other transportation, she has the right to appeal the decision.

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Medicare Annual Enrollment Period Starting Earlier This Year

Beginning this Fall, Medicare is moving up its Annual Enrollment Period (AEP) to run from **October 15th through December 7th**. Since the Medicare Part D Program started in 2006, the AEP had been November 15th through December 31st. However, the Affordable Care Act (enacted in March 2010) required Medicare to change the AEP by moving it up a month and extending the Enrollment Period from 47 days to 54 days. From October 15th through December 7th anyone with Medicare can make changes to their Medicare coverage by enrolling into a Part D Plan (or switching their plan), changing from a Medicare Advantage Plan to Original Medicare, or moving from Original Medicare into a Medicare Advantage Plan. For anyone who makes a change during the AEP, their new coverage will start on January 1, 2012.

As a reminder, the Medicare Advantage Open Enrollment Period that had run from January 1st to March 31st every year has been eliminated and replaced by an **Annual Disenrollment Period** that runs from **January 1st through February 14th**. During this period, anyone in a Medicare Advantage Plan can disenroll from their plan and go back to Original Medicare. If that beneficiary was in a Medicare Advantage Plan that included Part D drug coverage, she will also get a Special Enrollment Period that will allow her to enroll into a stand-alone Part D Plan.

Individuals who need assistance with 2012 plan choices should call APPRISE at 1-800-783-7067 or Medicare at 1-800-633-4227.

Important Dates for Medicare Beneficiaries

Between September 15-30: 2012 *Medicare & You* handbook will be mailed

By September 30: All plans must mail their members information about any changes for 2012. Consumers should review this information and determine if their current plan will continue to meet their needs in 2012 or whether they should be looking at other plan options.

October 1: Prescription Drug Plans and Medicare Advantage Plans start marketing for 2012.

By October 2: Plans that are not renewing their contract for 2012, or whose contract is terminated by Medicare, must send their members a letter notifying them that the plan will end December 31st.

October 6: Plan Ratings go live on Medicare Plan Finder (www.medicare.gov). This is also the tentative date for 2012 Plan information to be updated on www.medicare.gov.

October 15: Annual Enrollment Period (AEP) begins.

December 7: Annual Enrollment Period (AEP) ends.

January 1, 2012: Effective date of all AEP-related enrollments and disenrollments.

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2012 Costs for a Standard Medicare Part D Plan

Stand-alone Part D Plans and Medicare Advantage Plans that choose to offer "standard" Medicare Part D coverage must follow the cost-sharing structure and amounts that are established by the Centers for Medicare & Medicaid Services (CMS). Each year, CMS sets the cost-sharing amounts for standard Part D coverage.

2012 Part D costs will be higher than current costs. Medicare beneficiaries who do not qualify for a Low-Income Subsidy to help them with their Part D costs will pay the following for a standard Part D Plan in 2012:

- A monthly premium that can differ from plan to plan
- An annual deductible of **$320** (up from $310 in 2011)
- During their initial coverage period the consumer pays a 25% co-pay for each prescription until their total drug costs reach **$2,930** (up from $2,840 in 2011)
- During their coverage gap (also referred to as the "doughnut hole"), the consumer will pay a percentage of the costs of their drugs (in 2012 the consumer will get a 50% discount on brand-name drugs and a 14% discount on generics) until their total out-of-pocket expenses reach **$4,700** (this figure was $4,550 for 2011) and
- During the catastrophic coverage period consumers will pay co-pays of **$2.60** for generics and **$6.50** for name-brand drugs, or a 5% co-pay, *whichever is greater* (the current co-pays are $2.50 and $6.30)

More Medicare cost sharing information for 2012 will become available over the next few months and we will keep our readers apprised through upcoming Newsletters.

Part D "Extra Help" Redeterminations Under Way

Medicare and the Social Security Administration (SSA) are currently in the process of redetermining eligibility for the Part D Low-Income Subsidy (LIS), also known as "Extra Help", for 2012. The LIS dramatically reduces an individual's drug costs under Part D; specifically, it helps with the monthly premium and annual deductible, reduces coinsurance/co-pays for medications, and eliminates the doughnut hole/coverage gap. Certain individuals who currently get this benefit will receive redetermination forms in mail from SSA in September. **It is important that anyone who receives this form completes it and returns it within 30 days, even if nothing has changed**.

SSA will then send a notice to everyone who completes the redetermination form telling them one of the following messages:

(1) that there will be no change in their LIS starting January 1, 2012;
(2) that their LIS will increase or decrease starting January 1, 2012; or
(3) that their LIS will terminate starting January 1, 2012

Individuals who do not mail the redetermination form back will receive a follow-up (Continued on Page 4)

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phone call or letter from SSA in the late Fall. If they still do not send in the form after this follow-up attempt, then their subsidy will end on 3/31/2012.

LIS for Individuals Receiving *Any* Help From Medicaid (Dual Eligibles)

Individuals on Medicare who also get any help from Medicaid get the LIS automatically as a result of being a dual eligible. If an individual was receiving Medicaid benefits in any part of July 2011, he should be automatically approved for the subsidy for 2012 (this process is known as "redeeming"). These individuals will get the subsidy for all of 2012 even if they lose their Medicaid coverage before the end of next year. Individuals who no longer receive Medicaid benefits as of July 2011 will likely lose their automatic eligibility for the LIS as of January 1, 2012 and will be sent a notice to this effect in mid-September. This notice will be on grey paper. *Please note that if an individual gets this grey notice and goes back on Medicaid before the end of this year, they will be automatically approved again for the LIS for 2012.*

Consumers receiving the grey LIS termination notices are encouraged to call APPRISE at 1-800-783-7067 to see if they qualify for the LIS for 2012 (remember, their subsidy is only being terminated because they no longer ***automatically*** qualify for the LIS; they may still qualify but will need to apply to SSA). Individuals needing help completing the SSA redetermination form (discussed previously) are also encouraged to call APPRISE for assistance.

Those who remain on Medicaid will only get a notice if their subsidy co-pays will change in 2012 (this notice will be sent on orange paper). If there will be no change to their LIS in 2012, they will not receive any notice.

DPW Considering a Statewide Shared Living Program

In July, DPW Secretary Gary Alexander issued a Request for Information (RFI) from all interested stakeholders seeking comment and feedback about expanding Shared Living Programs in the Commonwealth. The state currently offers two programs that are considered Shared Living:

- The Family Living Services Program is run through DPW's Office of Developmental Programs. It is for individuals with intellectual disabilities who choose to live in the community with qualified unrelated adults in a household who provide them with the supports they need.
- The Domiciliary Care ("Dom Care") Program is operated by the Office of Long Term Living within the Department of Aging. It provides a community living arrangement for adults age 18 and older who need assistance with activities of daily living and are unable to live independently. These individuals choose to live in the home of the person/family providing them with supervision and supports.

DPW wants to determine whether establishing a Department-wide Shared Living Program while also enhancing and broadening the scope of existing programs (Family Living and Dom Care) will support its mission — that is, to improve upon and increase access to community services under Medical Assistance for those in need of long term living services. The target populations for the

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expanded Shared Living Program include:

- Individuals with disabilities, including seniors, who are at risk of, or currently living in, places like nursing homes, mental health institutions, personal care homes, etc.
- Individuals with disabilities who are homeless or at risk of becoming homeless
- Youth who are aging out of residential services but who cannot live in the community without ongoing supports
- Adults living at home who want to age in place

To review the RFI go to www.emarketplace.state.pa.us/FileDownload.aspx?file=RFI-DPW-ODP/Solicitation_1.pdf. DPW has extended the deadline for responding to the RFI to **September 30, 2011**. DPW asks that responses be filed electronically to Pam Kuhno at sharedliving@state.pa.us.

Uncertainty Remains About Impact of Federal Debt Deal on Medicare and Medicaid

In recent months, the Obama Administration and Congress have been wrestling over changing the federal government's long-term budget. Government spending on various programs including Medicare and Medicaid has been a focus in the discussions and negotiations. Here's a review of recent events and a preview of what's ahead:

- On July 31st, President Obama and Congressional leaders of both parties announced an agreement that would raise the limit on the amount of debt the federal government can incur (known as the debt ceiling). If the debt ceiling had not been not raised, the nation would have lost its ability to pay its debts and keep the federal government running. No one knows what would have happened because this has never happened before. The agreement allows the government to borrow until 2013, but it also calls for at least $2.4 trillion in spending cuts over 10 years.

- These cuts will be made in at least two stages. First, $900 billion "across the board" cuts will be enacted immediately. Medicaid and Medicare will not be impacted by this initial round of cuts. The first stage does not include any change in tax revenues.

- The second stage creates a 12-person bipartisan Congressional Committee (with an equal number of Democrats and Republicans from the House and Senate). U.S. Senator Pat Toomey is the only Pennsylvanian appointed to this Committee. By Thanksgiving, the Committee will have to come up with a plan for cuts or revenue enhancements necessary to reduce the deficit by an additional $1.5 trillion; the committee's plan would go straight to the floor of both chambers of Congress for an up or down vote. Medicaid and/or Medicare could be cut at this stage.

- To put pressure on the Committee, Congress' failure to enact the Committee's proposed cuts and/or revenue enhancements would trigger automatic spending cuts of $1.2 trillion to defense and non-defense discretionary spending. Medicaid, Medicare and other entitlements are exempt from these automatic cuts.

There is little known and much uncertainty about how Medicare and Medicaid will fare in the second stage. PHLP's newsletters and our website will keep readers informed in the months ahead.

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New and Improved Application for the Medicare Savings Program!

Applying for help with Medicare cost-sharing (premiums, deductibles, and coinsurance) should now be easier and result in people getting more help! In May, the Department of Public Welfare (DPW) updated their application for the Medicare Savings Program (also known as the "Medicare Buy-In"). On the new application, individuals are asked if there was a change in their income or assets within the last three months. The application will be automatically reviewed to determine if the applicant qualifies for payment of their Part B premium in the previous 3 months. In the past, the application did not tell people that they could request retroactive benefits or how to do that.

The new application has numbered questions and better explains what information is needed to establish eligibility for the Buy-In. Although the new application is longer than the old one, the questions are simpler and are better formatted so it should be easier to understand and fill out. Another change is that the Clients Rights and Responsibilities section has been moved from the end to the beginning of the application.

The revised application (PA 600M) is a result of the settlement of a class action lawsuit (Garcia vs. Johnson) between Community Legal Services and the Department of Public Welfare. All local County Assistance Offices may not yet have this new application available, but the application can be downloaded from DPW's website:
http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/s_002633.pdf.

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