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MATP Crisis Averted — For Now

In recent weeks, the Department of Public Welfare (DPW) has found funding to help avert a crisis in the Medical Assistance Transportation Program (MATP) across the state after a number of county programs threatened a full or partial shut-down. The MATP program statewide has faced severe fiscal problems this year as a result of a $26 million cut in funding under the current state budget enacted by the state legislature last June. Despite cost-savings measures that included a reduction in mileage reimbursement to 12 cents/mile and limiting out of county trips, counties started notifying DPW earlier this year that they were running out of money and would not be able to sustain their program through the end of the fiscal year. Six counties actually sent notices to consumers telling them that the county's MATP program was partially or totally shutting down due to lack of funding.

After learning about the threats of program shutdown across the state, the Consumer Subcommittee of the state's Medical Assistance Advisory Committee, acting through their counsel PHLP, responded immediately — demanding that the state stop counties from sending any further notices and urging the state to make every effort to find the money needed to sustain the MATP program. Thanks to the Consumers' strong advocacy, the state did issue a directive stopping the counties from sending out any additional shut-down notices. Even more importantly, DPW was ultimately able to identify additional monies that are being distributed to the county MATP programs so that they have all resumed normal operations. The state hopes the funds will be sufficient to shore up the MATP program until the end of the fiscal year which is June 30th.

DPW's proposed MATP budget for FY 2012-13 reflects an 8% increase over current program funding. Even if that entire amount is included in the final state budget approved by the legislature, however, it will likely not be sufficient to maintain the MATP program as it currently operates for another year. That means the state will be continuing to look at ways to cut costs or increase efficiencies in the delivery of medical transportation services. PHLP will keep our readers apprised of any further developments or changes to the MATP program in future newsletters.

INSIDE THIS EDITION

Certain Medicaid Co-pays To Increase Soon

Sliding scale co-payments for adults on Medicaid will increase starting May 15th. Only consumers who get their Medicaid through the fee-for-service system (those who obtain services using the PA ACCESS card) will be affected. Those enrolled in a Medicaid managed care plan will only be affected **IF** their plan adopts the increase and sends out its own notice.

DPW has already sent a written notice to affected individuals explaining the changes.

Note that this change does not increase **fixed** Medicaid co-payments, such as the $1 and $3 co-pays for generic and brand name prescriptions. It only increases **sliding scale** co-payments, which vary in amount depending on how much Medicaid pays a provider for a service. A doctor's office visit is an example of a service that has a sliding-scale co-pay. For consumers in General Assistance-related categories of Medicaid, the sliding scale co-pay amount is double that applied to other Medicaid consumers. The amounts of the copayment increases are tied to an inflation index. The increased co-payment amounts are as follows (the current co-pays are in parentheses):

> This change applies to individuals who have both Medicare and Medicaid, also called "dual eligibles". All dual eligibles receive their Medicaid coverage through the ACCESS card (regardless of what type of Medicare coverage they have). The ACCESS card covers the Medicare cost-sharing for dual eligibles; however, these individuals can still be charged Medicaid co-pays for the services they receive.

Medical Assistance (MA) *	
Amount DPW Pays	**Consumer Copayment Amount**
$2-$10	**$0.65** ($0.50)
$10.01-$25	**$1.30** ($1.00)
$25.01-$50	**$2.55** ($2.00)
$50.01 or more	**$3.80** ($3.00)

General Assistance (GA)	
Amount DPW Pays	**Consumer Copayment Amount**
$2-$10	**$1.30** ($1.00)
$10.01-$25	**$2.60** ($2.00)
$25.01-$50	**$5.10** ($4.00)
$50.01 or more	**$7.60** ($6.00)

**Dual eligibles are in the Medical Assistance categories of Medicaid and would therefore be charged the amounts in the MA table above.*

This change will **not** affect Medicaid consumers who are currently not required to pay any copayments, such *children under age 18*, *pregnant women*, and *residents of a long-term care facility*. The change will also **not** apply to services to which no co-payment is applied, such as emergency, laboratory, and home health agency services.

Medicaid services cannot be denied to consumers unable to afford the copayment.
An individual who cannot afford to pay a co-payment at the time of service should tell their provider. A provider can bill a consumer afterwards, but cannot withhold services for the consumer's failure to make a co-payment at the time of service.

HealthChoices Open Enrollment Starts in May For Medicaid Recipients in 7 Counties

Most individuals who live in Blair, Bedford, Cambria, Franklin, Fulton, Huntingdon, and Somerset Counties **and** who have Medicaid will soon have to join a managed care plan for their physical health coverage. ***ACCESS Plus will no longer exist in these counties as of July 1st.*** As of this date, these counties will join existing HealthChoices zones. HealthChoices is the term used for mandatory managed care in the Medicaid program.

Bedford, Blair, Cambria and **Somerset** counties will become part of the ***HealthChoices Southwest Zone***. Medicaid consumers in those counties can enroll in any of the four managed care plans available in the Zone:

- Coventry Cares
- Gateway Health Plan
- United Healthcare Community Plan
- UPMC for You

Franklin, Fulton and **Huntingdon** counties will be incorporated into the ***HealthChoices LehighCapital Zone***. The Medicaid consumers in those counties will have the following managed care plans to chose from:

- Aetna Better Health
- AmeriHealth Mercy Health Plan
- Gateway Health Plan
- United Healthcare Community Plan
- UPMC for You

The Open Enrollment Period to choose a managed care plan will begin May 10th. Consumers in the seven counties will receive written information about the HealthChoices expansion and their plan choices in early May. Consumers will be asked to enroll in a plan and choose a primary care practitioner (referred to as a PCP), who will provide most of the consumer's primary care and who will make a referral if the consumer needs to see a specialist. ACCESS Plus members who do not choose a plan by June 14th will be auto-assigned to a plan by DPW. The plan enrollments will take effect on July 1, 2012. Individuals who are currently enrolled in a voluntary managed care plan will remain in that plan unless they take action to join a new plan.

Unlike ACCESS Plus, consumers in HealthChoices are restricted to health care providers (including dentists and vision care providers) that are in their health plan's network. Consumers can only go to a provider out of the network, and have it covered by the plan, if their health plan approves the out-of-network referral in advance.

Before enrolling in a plan, consumers should check with their providers (i.e., PCP, specialists, hospitals) to determine if they are in the network of any of the HealthChoices plans and then enroll in the plan that would allow them to keep most, if not all, of their important providers. Consumers should also check that the plan covers their medications as each plan has a different list of drugs (called a formulary) they will cover.

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The following groups of individuals will **not** be affected by this HealthChoices expansion:

- **Dual Eligibles**: individuals who have Medicare and Medicaid do not participate in HealthChioces for physical health care coverage. These individuals receive their Medicaid physical health coverage through the fee-for-service system (ACCESS card).
- **Aging Waiver recipients**: older adults who receive services through the Aging Waiver stay in the Medicaid fee-for-service program for their Medicaid coverage (regardless of whether they have Medicare or not).
- **LIFE program participants**: individuals receive Medicare and Medicaid services through LIFE.
- **Breast and Cervical Cancer Prevention and Treatment Program recipients**: women who are eligible for Medicaid under this program remain in the fee-for-service system for their Medicaid coverage.
- **Individuals enrolled in the Health Insurance Premium Payment (HIPP) program**: these individuals remain in the fee-for-service system for their Medicaid coverage.

What Happens When I Become a Dual Eligible?

(Part 1 in a Series)

Each month through our Helpline, PHLP talks to individuals (or to their family members, advocates and 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 get limited coverage through Medicaid such as having Medicaid pay for the Medicare Part B premium). In this newsletter and in upcoming issues, we'll review what happens when someone becomes a dual eligible and what, if any, actions they need to take.*

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

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. If someone is on full Medicaid when Medicare starts, here's what she needs to know:

- ***Medicaid coverage will be through the fee-for-service system (ACCESS card)*** — If someone was getting their Medicaid benefits through a managed care plan or ACCESS Plus, she will be taken out of that coverage shortly after Medicare starts and moved to the fee-for-service system. Medicare will be her primary insurance and Medicaid will become her secondary coverage.

  Action needed: She will need to start showing both her ACCESS card **and** her Medicare card when she gets health care services. If she does not have an ACCESS card, she needs to contact her caseworker at the local County Assistance Office or contact the Customer Service Center (1-877-395-8930) to request a new card. Please note that if someone is also getting food stamps, they will use the greenish-blue EBT ACCESS card for medical coverage. If someone is not getting food stamp benefits, they will use a yellow ACCESS card.

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- ***Medicaid will no longer cover most prescription drugs*** — Dual eligibles get their prescription drug coverage through Medicare Part D. The ACCESS card will only cover limited types of medication (classes of drugs that are now excluded from coverage under Part D such as benzodiazepines, barbiturates, and some over-the-counter medications).

  Action needed: She will need to join a Medicare Part D plan. Each Part D plan differs in terms of costs, drug coverage and pharmacy network. To be sure that someone is in the best plan for them, she should join a plan that she can afford and that covers most, if not all of her medications. Individuals can join a stand-alone drug plan or a Medicare Advantage Plan with prescription coverage (including Special Needs Plans for dual eligibles). Individuals joining a Medicare Advantage Plan also need to be sure all of their health care providers (physical health, mental health, and pharmacy) are in the plan's network. Individuals who need help with Part D plan choices can contact MEDICARE (1-800-633-4227), the APPRISE program (1-800-783-7067), or PHLP (1-800-274-3258).

  Dual eligibles who do not take action to join a Part D plan will be auto-enrolled into a plan randomly by Medicare. The plan they are enrolled in will then send them a Welcome Letter and membership information (including an ID card). Individuals should take the letter or ID card to the pharmacy when they get medications.

  New dual eligibles who go to the pharmacy to get their drugs but who are not able to get them because they do not yet have active Part D prescription coverage should ask their pharmacy to bill LI NET (the back-up Part D plan for dual eligibles). The pharmacy can call 1-800-783-1307 for information about how to bill LI NET.

  Individuals can call 1-800-MEDICARE to find out if they have any current Part D coverage. It is important to remember that if dual eligibles find themselves in a Part D plan that does not meet their needs, they can change their plan at any time during the year! Coverage starts the first of the month after enrolling in the new plan.

- ***Dual eligibles receive the full amount of "Extra Help" with Part D costs (this is also called the full low-income subsidy) —*** All dual eligibles **automatically** qualify for the full subsidy from Medicare to help with Part D plan premiums and co-pays at the pharmacy. In 2012, there are 12 stand-alone drug plans whose premium will be completely covered by the full subsidy (for a list of these plans, see our website at www.phlp.org). With the full subsidy dual eligibles will not have to meet a deductible and they are not subject to the Part D "donut hole". Instead, they will only pay small co-pays at the pharmacy of either $1.10/$2.60 for generic medications and $3.30/$6.50 for brand name medications. The amount charged depends on someone's income. Dual eligibles who are in a long-term care facility (i.e., nursing home) or who receive long-term care services at home through a Waiver program **do not have any** Part D co-pays.

  Action Needed: None. Duals should automatically receive this extra help from Medicare without needing to do anything; however, dual eligibles who are being charged higher amounts than those listed above at the pharmacy should contact 1-800-MEDICARE or PHLP because there might be a problem with the subsidy.

Upcoming newsletters will include a review of what happens when someone on Medicare becomes eligible for Medicaid (Part 2) and partial dual eligibles (Part 3).

Fran Chervenak Receives 2012 PLAN Excellence Award

Fran Chervenak, PHLP's Director of Client Services and Managing Attorney of the Pittsburgh office, was honored by the Pennsylvania Legal Aid Network (PLAN) at its annual awards banquet. Fran has dedicated her entire career to legal services. Prior to joining PHLP in 1998, she worked at the Legal Aid Society of Minneapolis.

Fran has helped thousands of individual clients during her time at PHLP and has a reputation as a competent, caring advocate and a terrific mentor and teacher. Fran provides counsel to the Consumer Subcommittee of the Medical Assistance Advisory Committee as well as the consumers appointed to the state's Medical Assistance Transportation Advisory Committee. She is an expert on the delivery of health care to Pennsylvania's dual eligible population.

Fran's passion for the clients we serve and her work are remarkable. She thinks she's just doing her job but those of us who work with her and clients who have worked with her know that is a real understatement. To see PLAN's tribute video to Fran, visit PLAN's website at www.palegalaid.net/services/leadership/awards .

Congratulations to Fran and the other 2012 PLAN Excellence Award Winners!

Do you currently get the Health Law PA News through the mail? Would you like to get these newsletters by e-mail?

If so, contact staff@phlp.org to change the way you get your PHLP newsletters!

State Plan on Aging Update

The Department of Aging continues to develop the 2012-2016 State Plan on Aging that will guide future services provided to older Pennsylvanians. State and federal law requires states to develop and submit a State Plan every four years in order to receive Older Americans Act funds.

The State Plan identifies the Department's priorities and sets an agenda for the Commonwealth. Focus areas of the upcoming Plan include:

- Promoting health and well-being-care transition, nutrition, chronic disease
- Supporting communities as places to age and live well
- Revitalizing and redesigning Aging Services
- Promoting the incubation of innovation through research, public-private partnerships, and good ideas.

The process began at the end of last year with a meeting of the Pennsylvania Council on Aging and the Pennsylvania Association of Area Agencies on Aging. Consumer focus groups are now being held across the state to obtain input. The 52 Area Agencies on Aging will submit their area plans to the state in May 2012. Area Plans will be reviewed between June and August and public hearings will be held in June and July. The Department of Aging will then develop the State Plan using information from the area plans, focus groups, and the public hearings. The State Plan is due in August.

Individuals can find more information about the State Plan on Aging at aging.state.pa.us. The Department is accepting comments by e-mail at RA-StatePlanOnAging@state.pa.us or by phone at 717-783-1550. Individuals can also contact their local county Area Agency on Aging to provide input.

No MATP Co-Pays for Shared Ride Services

The Department of Public Welfare (DPW) has decided to not implement co-pays for the Medical Assistance Transportation Program (MATP). As we reported in our February newsletter, co-pays of $2 each way for shared ride services were to begin May 1st as part of DPW's cost-savings initiatives to make up for a $26 million cut to MATP funding in the FY 2011-2012 budget. However, the Department received a number of comments back from various stakeholders about the MATP co-pays after regulations were issued in February. As a result, DPW has decided it will not go forward with imposing co-pays for shared ride services under MATP.

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.

Improved Medicare Summary Notice Available Online

In March, Medicare started to use a new, improved Medicare Summary Notice that is easier for beneficiaries to read and understand. Summary notices, which are mailed to beneficiaries on a quarterly basis, show all the claims that providers have submitted to Medicare during the quarter , what services have been covered or denied, what Medicare paid and what someone's cost-sharing responsibility might be for services.

The new notices use larger fonts and a new format to make it easier to read. They also use simpler, more consumer-friendly language and define all the terms used in the notice. Medicare hopes it will be easier for individuals to identify incorrect billing (whether a simple mistake by the provider or a case of fraud). It also includes more and better information about how to appeal if a service is denied. The improvements to the notice were made after getting feedback from focus groups of Medicare beneficiaries around the country and getting suggestions from consumer advocacy groups about how to improve the notices.

Right now, the new notice is only available online (through www.mymedicare.gov which requires registration by a Medicare beneficiary). The new notices will be mailed to beneficiaries starting in 2013. Individuals can see a comparison of the old and new notices at http://www.cms.gov/apps/files/msn_changes.pdf.

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