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"Healthy PA" Proposes Significant Changes to Medicaid

In early December, Governor Corbett unveiled "Healthy Pennsylvania" — a far reaching proposal that expands eligibility for Medicaid-funded health insurance for adults age 21 to 64, but also significantly changes the amount and scope of Medicaid-covered benefits, imposes new premiums, and requires certain Medicaid beneficiaries to participate in job search activities. The plan is currently in a public comment period which ends January 13, 2014. The Administration will review and consider the comments received, possibly revise its plan, and submit the proposal to the federal Centers for Medicare and Medicaid Services (CMS) for review and approval.

The Healthy Pennsylvania proposal does **not** apply to individuals age 65 and older; however, it will impact younger seniors (ages 60-65) and people with disabilities as detailed below.

Expanding, and in Some Cases Changing, Medicaid Eligibility

Under the Administration's proposal, Medicaid is expanding for adults age 21-64 with income up to 133 percent of the federal poverty level who do not currently qualify for Medicaid (generally because they do not fit into a current category of eligibility such as having a disability, needing health sustaining medications, being pregnant or living with minor children). Rather than simply enroll these newly-eligible persons into the existing Medicaid program, the state would instead use Medicaid dollars to buy them coverage through the Health Care Marketplace. These consumers would not have all the rights and protections that those on Medicaid have, such as the right to continued benefits pending appeal, but only those rights and protections available to enrollees of a Marketplace plan.

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(Continued from Page 1) For those currently on Medicaid or who apply in the future, eligibility for some populations will stay the same, while others will have to meet additional criteria to obtain or retain Medicaid coverage. The Healthy Pennsylvania proposal:

- Eliminates the Medical Assistance for Workers with Disabilities (MAWD) program and the General Assistance Medical Assistance program. Individuals who qualified for those programs who have income less than 133 percent FPL (and who are **not** on Medicare) would instead be covered through the expansion of Medicaid described above.
- Imposes a monthly premium and work search requirements (both described later in this article) on those age 21 to 64, including those who qualify for Medicaid based on having a disability that is permanent or lasting at least a year or as a recipient of Home and Community Based Services (HCBS) Waiver services, unless they fit into one of the groups exempted from these requirements as described later or are otherwise granted an exception.

The proposal does **not** change how certain groups of people qualify for Medicaid benefits including pregnant women, children under the age of 19, individuals age 65 and older, people who are institutionalized, people receiving Supplemental Security Income (or who are deemed as SSI recipients by Medicaid), those dually eligible for Medicare and Medicaid, and those whose Medicaid category limits them to Medicare cost-sharing (i.e. Qualified Medicare beneficiaries).

Changing Medicaid Benefits

Under the Healthy Pennsylvania proposal, health care coverage for those under age 21 or over age 65 is **not** changing. For those on Medicaid who are age 21 to 64, the state proposes to eliminate the current system where an adult is assigned to one of 14 health care benefit packages based on category of eligibility. Instead, adults on Medicaid would be screened and enrolled into either a "low risk benefit plan" or a "high risk benefit plan". SSI recipients, pregnant women, those dually eligible for Medicare and Medicaid, residents of institutions and those receiving HCBS Waiver services will be automatically enrolled into the high risk benefit plan.

The differences between the low risk and the high risk plan are substantial. For example: outpatient surgery is limited to two visits per year (low risk) versus four visits/year (high risk); outpatient mental health treatment is limited to 30 visits/year (low risk) versus 45 visits a year (high risk); durable medical equipment is limited to $1,000/year combined with supplies (low risk) versus $2,500/year (high risk). Exceptions to the benefit plan limits can be granted if the state determines 1) the consumer has a serious illness or health condition and failing to grant the exception will jeopardize the person's life or result in their serious deterioration, or 2) granting the exception is a cost-effective alternative for the Medicaid program.

Monthly Premiums for Adults

In the current Medicaid program, cost-sharing for adults is generally limited to small co-pays for various covered services, and the only individuals charged a monthly premium are those eligible through the Medical Assistance for Workers with Disabilities (MAWD) program. Under the Healthy Pennsylvania proposal, co-pays would be eliminated and all adults age 21-64 **with income above 50 percent of the federal poverty level** would be required to pay a monthly premi-

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(Continued from Page 2) um of $13-$25 depending on their income, unless they fall into an exempt group. Those exempt from a monthly premium are:

- Pregnant women;
- Those age 65 or older;
- SSI recipients and those deemed SSI eligible by Medicaid;
- Dual eligibles on Medicare and Medicaid; and
- Those who are institutionalized

Please note: Individuals under age 65 who do not have Medicare and who are eligible for Medicaid under Healthy Horizons (individuals who have a disability that is permanent or expected to last at least 12 months), or because they receive HCBS Waiver services, would be subject to these new premium requirements.

Premiums could be reduced by participating in certain healthy behaviors (i.e. having an annual physical) and/or by working 20 or more hours per week. Those who are required to pay a premium and who fail to comply will be excluded from receiving Medicaid for three months or more depending on the number of episodes of non-compliance.

Work Search

Under Healthy Pennsylvania, adults age 21-64 who are working less than 20 hours per week will be required to register with JobGateway and engage in work search activities each month to maintain their eligibility. Those exempt from the work search requirements include individuals in any of the exempt groups listed above plus full or part-time students and those receiving Temporary Assistance for Needy Families cash benefits. Again, individuals under age 65 who do **not** have Medicare and who are eligible for Medicaid based on having a disability or because they receive HCBS Waiver services would be subject to these new requirements.

Those required to participate in work search activities and who fail to comply will be excluded from receiving Medicaid for three months or more depending on the number of episodes of non-compliance.

Opportunity for Public Comment

Clearly, the Governor's Healthy Pennsylvania plan proposes dramatic changes to the current Medicaid program and will affect the ability of some younger seniors and adults with disabilities to qualify for Medicaid and/or obtain coverage for the services they need to sustain their health and well-being. Readers can view the entire Healthy Pennsylvania proposal and find information about public hearings that are being held statewide here. Consumers and their family members, health care providers and advocates can submit comments to the proposal. In October, PHLP articulated a number of concerns about the concept and will submit similar comments to state officials about the proposal. **The deadline for written comments is January 13, 2014.** Written comments can be submitted by email to RA-PWHealthyPA1115@pa.gov or by mail to:

Department of Public Welfare
Attn: Healthy Pennsylvania Waiver
P.O. Box 2675
Harrisburg, PA 17105-2675

Resource Limits Increasing for Programs that Help with Medicare Costs

The resource limits someone must meet to qualify for programs that help lower their Medicare costs are increasing as of January 1, 2014.

Medicare Savings Programs

These programs pay the Medicare Part B premium ($104.90/month in 2014) for individuals who meet certain income and resource limits. In 2014, the resource limits to qualify for these programs are $7,160 (if single) and $10,750 (if married). This represents an increase of approximately $80 if single and $130 if married from the previous limits of $7,080 and $10,620. Income limits also apply—applicants must have income below 135% FPL (currently $1,293/month if single and $1,745/month if married) to qualify for this help.

Medicare Part D Low-Income Subsidy/Extra Help with Medicare Prescription Drug Costs

The Low-Income Subsidy (LIS) program helps lower the amount of money people pay for their Medicare prescription drug coverage (Part D). The subsidies lower the amount of premium someone has to pay for their Medicare prescription drug plan, eliminates any Part D "donut hole", and limits the deductibles and co-pays they pay at the pharmacy when they get their medications. There are two levels of help-full and partial. Individuals generally must meet income and asset guidelines to qualify for any level of help.

- To qualify for a **full subsidy** in 2014, someone's income must be under 135 percent FPL (figures given above) and her resources must be under $8,660 if single and $13,750 if married.
- To qualify for a **partial subsidy** in 2014, someone's income must be under 150 percent FPL (currently, $1,436/month if single and $1,939/month if married) and her resources must be under $13,440 if single and $26,860 if married.

Important information to note about qualifying for a low-income subsidy***:***

- If someone has Medicare and gets ***any*** level of help from Medicaid, then they are considered a dual eligible and automatically qualify for the full subsidy regardless of their income and resources.
- The resource limits given above include a $1,500 per person disregard that is given to all applicants unless they note on the application that they do NOT plan to use their resources for funeral or burial expenses.

Medicare beneficiaries who need help applying for these programs, or who have questions about how to qualify, should contact APPRISE (Pennsylvania's State Health Insurance Program) at 1-800-783-7067 or through their local Area Agency on Aging Office. As noted in previous newsletters, APPRISE representatives are available to help people learn about these programs and help individuals with applications to qualify for this help. If someone applied for these programs and has been denied, please contact the Pennsylvania Health Law Project Helpline at 1-800-274-3258 for assistance.

DMEPOS Round 1 Re-bid Goes Into Effect January 2014

Since January 2011, original Medicare beneficiaries who live in certain parts of western Pennsylvania have been required to use only contracted suppliers in order to get many types of medical equipment covered through Medicare. Round One of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program affected beneficiaries who live in nine areas of the country including 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. The current contracts for Round One suppliers ended December 31, 2013, and under the law, CMS was required to rebid the program and enter into new provider contracts. That process is complete and the new contracts took effect January 1, 2014.

Round 1 Re-Bid Changes

In re-bidding the program for Round One areas, CMS added more types of medical equipment and supplies to the list of items covered by the DMEPOS Program. Beginning January 1, 2014, Original Medicare beneficiaries in the Pittsburgh Competitive Bidding Area must now use only contracted suppliers chosen by Medicare to get coverage for the following types of equipment and supplies (the items underlined below are new and were not part of the DMEPOS program prior to January):

- Oxygen, oxygen equipment, and supplies;
- Standard (Power and Manual) wheelchairs, scooters, and related accessories;
- Walkers and related accessories;
- Enteral Nutrients, equipment and supplies;
- Continuous Positive Airway Pressure (CPAP) devices , Respiratory Assist Devices (RADs) and related supplies and accessories, and standard nebulizers;
- General Home Equipment and related supplies and accessories including Hospital beds, group 1 and group 2 support surfaces (mattresses and overlays), transcutaneous electrical nerve stimulation (TENS) devices, commode chairs, patient lifts, and seat lifts;
- Negative Pressure Wound Therapy pumps and related supplies and accessories; and
- External Infusion pumps and supplies.

In re-bidding for the Round One areas, CMS also contracted with some new suppliers who were not involved in the program previously. Original Medicare beneficiaries can obtain a current list of contract suppliers by typing in their zip code and the type of equipment needed into the DMEPOS Supplier Locator Tool at www.medicare.gov/supplier or by calling Medicare at 1-800-633-4227.

Generally, Original Medicare consumers must use a contract supplier if the item or service they need is included under DMEPOS and if they live in or are visiting the Pittsburgh Com-

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(Continued from Page 5) petitive Bidding area. A consumer can continue to use a current supplier that does not have a new contract if:

- The supplier elects to be "grandfathered", and
- The beneficiary permanently lives in the Pittsburgh Competitive Bidding Area, and
- The consumer is already renting certain equipment or oxygen when the program starts.

Reminder: The DMEPOS Program only affects how beneficiaries in **Original Medicare** obtain their durable medical equipment and supplies. Beneficiaries enrolled in Medicare Advantage Plans are not affected by DMEPOS and can continue to use any suppliers authorized by their Plan.

For more information on the DMEPOS Program, readers can go to: www.cms.gov/Outreach-and-Education/Outreach/Partnerships/DMEPOS_Toolkit.html

Medicare Drug Coverage in 2014: What to Keep in Mind

Making Plan Changes During the Year

The Annual Enrollment Period for people to change their Medicare Advantage or their Medicare drug plan ended December 7th. Generally, Medicare beneficiaries are locked in to their plan choices for 2014 and can only change during the year if there is another applicable enrollment period or if they qualify for a Special Enrollment Period.

Each year, the **Medicare Advantage Disenrollment Period** runs from January 1st to February 14th. During this period, someone who is enrolled in a Medicare Advantage plan can drop that plan and switch back to Original Medicare. These individuals can then also join a stand-alone drug plan for drug coverage ***if*** their Medicare Advantage plan included drug coverage. These are the ***only*** changes that can be made during this period. People cannot use this Disenrollment Period to switch to a different Medicare Advantage plan nor can they use this period to change prescription drug plans.

Medicare has a number of **Special Enrollment Periods** to address certain populations and certain circumstances. If someone meets the requirements for a Special Enrollment Period (SEP) they can use that SEP to change Medicare plans or even join or leave a Medicare drug plan or Medicare Advantage Plan outside of the normal enrollment periods. For anyone using a SEP to make a plan change, the new plan starts the first of the month after the change is made. Below is a list of some of the more common SEPs:

- Dual eligibles: have an ongoing SEP and can change plans at any time, or even multiple times, during the year.
- Low-Income Subsidy recipients: have an ongoing SEP and can change plans at any time, or even multiple times, during the year.

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- Individuals who lose LIS: have a one- time SEP that runs from January 1st - March 31st. Individuals who had the LIS in 2013, but who lost it as of the end of the year can switch plans or join or leave a Medicare drug plan or a Medicare Advantage plan during this period.
- Individuals in plans that terminated at the end of 2013: have a one-time SEP that runs from December 8, 2013-February 28, 2014. Individuals whose 2013 plan no longer provides coverage in 2014 can join a new plan during this period.
- Members of State Pharmaceutical Assistance Programs (i.e., PACE/CRDP/SPBP): Individuals who receive help through one of these State Pharmaceutical Assistance Programs have a one-time SEP that allows them to join a Medicare prescription drug plan (or make a change to their prescription coverage) at any time during the year.

These are just some of the various Special Enrollment Periods that exist. Individuals can contact Medicare (1-800-633-4227), APPRISE (1-800-783-7067), or PHLP (1-800-274-3258) to see if these or any other Special Enrollment Period would apply to them and allow them to enroll in a Part D plan or change Part D coverage outside of the normal enrollment timeframes.

Reminder about Part D Plan Transition Requirements

Within the first 90 days of coverage in a new plan year (starting January 1st), Part D plans must offer a temporary supply of medications for new enrollees who have been taking a drug that is either not included in the Plan's formulary or that requires authorization from the plan before it can be covered. This transition requirement also extends to current enrollees affected by changes to a plan's formulary from one year to the next. The one-time temporary supply (a 30-day refill) is to be provided to allow time for the prescriber to either switch the person to another appropriate medication covered by the plan, or to seek authorization or a formulary exception from the plan. These transition rules also apply to the first 90 days of coverage when someone switches plans during the calendar year.

Part D Coverage of Benzodiazepines and Barbiturates

When Medicare Part D first started in 2006, drugs that were classified as benzodiazepines and barbiturates were excluded from Part D coverage. Beginning in 2013, benzodiazepines were no longer excluded from coverage and barbiturates used to treat cancer, epilepsy, and chronic mental health disorders were also covered by Part D. Effective January 1st, barbiturates that meet the definition of a Part D drug are covered for any medically-accepted indication.

Because these types of drugs are no longer excluded from Part D coverage, dual eligibles on Medicare and Medicaid must get these medications through their Part D plan. If someone's Part D plan doesn't cover their benzodiazepine or barbiturate, they should talk to their doctor about possibly changing medications to one that is covered by their plan or having their doctor request a formulary exception. The ACCESS card no longer covers these medications for dual eligibles.

SilverScript Released from Medicare Sanctions

SilverScript, a Medicare Prescription Drug Plan sponsor, has been under sanction by Medicare since January 2013. While under sanction, SilverScript was not allowed to market their plans or enroll new members. Medicare recently announced that sanctions were lifted as of January 1st.

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(Continued from Page 7) SilverScript offers three stand-alone prescription drug plans in Pennsylvania in 2014, including one that is both a zero-premium plan for individuals who qualify for the full low-income subsidy (LIS) and a partner plan with PACE/PACENET (*SilverScript Basic*). None of the plans were listed in the 2014 Medicare and You Handbook that all Medicare beneficiaries received this fall, nor were they listed as available plans on the Plan Finder tool on www.medicare.gov prior to January 1st. However, now that the sanctions are lifted, SilverScript can start marketing their plans and enrolling new members. The plans are also now listed as options on the Medicare Plan Finder tool.

Even though the sanctions are lifted, Medicare will **not** auto-enroll low-income subsidy recipients into the *SilverScript Basic* plan at this time. Medicare will continue to monitor SilverScript to evaluate whether any previous problems which led to the sanctions recur. Auto-enrollments will only begin once Medicare is satisfied with SilverScript's enrollment performance.

Individuals Who Have to Pay for Medicare Part A Can Choose Marketplace Coverage Instead

The Centers for Medicare & Medicaid Services (CMS) continues to clarify the information it disseminates about when someone who is over the age of 65 might be able to purchase insurance through the Marketplace, and receive premium tax credits, instead of purchasing Medicare. Generally speaking, most Medicare beneficiaries cannot buy coverage through the Marketplace. However, in either of the following certain circumstances, someone could choose to have Marketplace coverage instead of Medicare:

- Individuals who are **eligible for Medicare but not yet enrolled** (either because they would have to pay a premium for Part A coverage or because they are not collecting Social Security benefits).
- Individuals who **have Medicare coverage and are paying a premium for Part A**. Most people get Medicare Part A for free; however, some individuals have to pay for Part A coverage because they (or their spouse) have not worked and paid Medicare taxes for at least 40 quarters. In cases where someone is buying Part A, she could choose to drop her Medicare coverage entirely and instead buy coverage through the Marketplace.

Individuals in these situations need to consider Medicare late-enrollment penalties and Medicare enrollment periods, as well as costs and health plan benefits of Marketplace coverage when making the decision to go through the Marketplace instead of Medicare.

Individuals age 65 and older who do not yet have any Medicare coverage, or who are paying for Part A, can contact the Marketplace by phone (1-800-318-2596) to discuss coverage options and possible eligibility for premium tax credits. More information can be found in a Medicare publication on this topic here.

Scathing Report Highlights DPW's Lack of Oversight of Providers That Pay Caregivers of Individuals Receiving Long-Term Care Services In their Homes

In November, Pennsylvania's Auditor General released a report detailing findings of a performance audit of the Department of Public Welfare (DPW) that identified long-term mismanagement of providers that pay direct care workers under Medicaid Waiver programs. According to the report, this mismanagement caused undue financial and emotional strain on tens of thousands of people, and resulted in significantly higher costs to the Pennsylvania Medicaid program and to taxpayers. The audit focused on the duties and responsibilities of DPW as it relates to financial management services (FMS). It began after a high volume of calls were made earlier this year to the Department of the Auditor General, and to members of the PA Legislature, from individuals receiving Waiver services and from their direct care workers who were not getting paid timely or correctly.

Readers may recall previous newsletter articles about significant problems with payments to caregivers of individuals receiving long-term care services at home through Home and Community Based Services Waiver programs. Several Waiver programs (Aging, Attendant Care, OBRA, COMMCARE, Independence, Consolidated and Person/Family Directed Support) allow for "consumer-direction" of certain services such as personal care services. Individuals in these Waiver programs who choose consumer direction have the authority to hire, train, schedule and supervise their workers thereby giving them the most control over the care. If someone uses the consumer model, she also receives FMS services to handle the administrative tasks associated with being an employer: tasks such as issuing paychecks and withholding taxes.

Prior to 2013, 36 different agencies across the state provided these FMS services. DPW decided to reduce the number of providers of this service and began to use one statewide vendor, Public Partnerships Limited LLC (PPL), beginning in January 2013. Over 20,000 waiver consumers transitioned to the new vendor for FMS. The report notes that thousands of their direct care workers had paychecks delayed for up to four months. These payment problems led some of the individuals receiving Waiver services to switch and go through an agency to provide them with a caregivers/home care workers or to go to a nursing home-both of which are more costly to the Medicaid program and to taxpayers.

The main findings of the audit include:

- DPW's poor oversight of the FMS providers in place even prior to PPL's contract led to undue stress and financial strain for hundreds of direct care workers;
- DPW's procurement process was unfair to other vendors who might have bid lower and ultimately performed better;
- DPW's mismanagement of the FMS transition led to thousands of direct care workers not getting paid on time. DPW ignored numerous red flags, thereby missing the opportunity to ensure that waiver participants transited to PPL as seamlessly as possible;
- DPW incurred additional costs with PPL and did not achieve expected efficiencies;
- DPW continues to put the well-being of Waiver participants and direct care workers at risk by not adequately monitoring PPL; and

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- DPW failed to ensure that only allowable hourly wage rates were paid to direct care workers and permitted this noncompliance to continue for years.

The report made several recommendations for DPW to follow in order to improve its oversight of these services now and going forward. The recommendations urged DPW to conduct initial and ongoing reviews of PPL to determine compliance with all applicable laws, regulations and standards, and to take quick, specific action when they find noncompliance. DPW disagreed with all of the performance audit findings and said they'd "consider" the recommendations made. The entire report can be viewed here.

PA Reports Challenges with Tens of Thousands of Medicaid File Transfers From Federal Website

In early January, Pennsylvania officials announced that at least 25,000 low-income Pennsylvanians who applied for coverage on www.HealthCare.gov between October 1st and December 24th, **and** who were found potentially eligible for Medicaid, have not been able to enroll in that coverage. Problems with data transfers between the federal government and the Pennsylvania's Medicaid program is preventing enrollment.

If you applied on www.HealthCare.gov and were found eligible or potentially eligible for Medicaid:

- You can expect to receive a call from the Marketplace Call Center within the next few days which will recommend you re-apply for Medicaid directly with DPW by calling **1-866-550-4355.**
- If you applied between October 1st and December 24th, and have not been enrolled due to this delay, your coverage will be retroactive to January 1, 2014 if you are approved for Medicaid.

If you applied directly to Pennsylvania Medicaid or CHIP and were found eligible:

- You do not need to take any further action.

If you applied directly to Pennsylvania Medicaid or CHIP and were found ineligible:

- You were notified by the state that your application was referred to the Marketplace for health insurance.
- You will be contacted by the Marketplace with more information and next steps.
- You do not need to wait to hear from the Marketplace; you can apply for coverage directly through the Marketplace by visiting HealthCare.gov or calling **1-800-318-2596**.

Federal PCIP Extended Through January

Recently, the Obama Administration announced that it would be extending the Preexisting Condition Insurance Program (PCIP) until the end of January. In Pennsylvania, PA FairCare provided this coverage until July 2013, when enrollees were transitioned to the federally run PCIP.

Originally, the PCIP was set to terminate at the end of December 2013 since all insurers were required to provide coverage to those with preexisting conditions starting on January 1, 2014. However, because of ongoing difficulties with enrollment through the Marketplace, that end date has been pushed back a month to ensure that current PCIP enrollees do not face a coverage gap. As a result, individuals in PCIP who do not yet have other health care coverage, will continue to have PCIP coverage through the end of January as they explore options through the Marketplace and enroll into a plan. In order to assure they have health coverage after January 31st, current PCIP enrollees should make sure to enroll into a new health insurance plan by January 15, 2014 for coverage to start February 1st.

Health Law News to Be Published Monthly

For years, PHLP has published two bi-monthly newsletters, the *Health Law PA News* and the *Senior Health News*. However, this will be the last edition of the *Senior Health News*.

Effective January 2014, these two newsletters will be combined into a single monthly publication titled *Health Law PA News*. This will allow us to ensure our readers have timely access to important information. The combined newsletter will continue to report on topics of specific interest to seniors and persons with disabilities, such as Medicare, the Medicare Savings Program, the Medicare Part D Low-Income Subsidy/Extra Help, and Home and Community Based Services Waiver programs.

If you have questions or would like to change your subscription settings, please email staff@phlp.org.

Happy New Year from PHLP!

As 2013 ends and 2014 begins, PHLP thanks all of our colleagues and supporters that helped us stand by people in distress; people whose physical and mental well being was compromised by illness. Last year we handled over 5,000 cases for people with health care needs. These cases keep us grounded and push us to keep fighting for Pennsylvania's most vulnerable.

There is much work ahead, especially as federal and state officials debate Medicaid expansion and reform. Please consider us when you are making contributions to charitable organizations. Donations can be made by mail or by using our secure online form at www.phlp.org.

We wish you good health, and hope you will continue to stand for health care access in the new year!