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Statewide Helpline: 800-274-3258
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DPW Delays MA Co-Pays for Families of Children with Disabilities Indefinitely

On October 5th, the Department of Public Welfare (DPW) Secretary Gary Alexander announced that the co-pay initiative for certain families of children with disabilities who receive Medical Assistance (MA) through the PH-95 category is delayed until further notice. The co-pays started October 1st for children newly eligible for this category of MA coverage and were scheduled to start November 1st for approximately 38,000 current recipients. Notices about the co-pays were sent to affected families at the end of September.

Secretary Alexander's statement about the delay indicated that the Department will continue to work with stakeholders to try and get approval from the federal government to charge families' premiums as opposed to co-pays as premiums would be simpler to administer. However, the federal agency that oversees Medicaid (known as MA in Pennsylvania) has stated that imposing premiums would violate federal law. DPW stated it would seek special permission from the feds to impose premiums. It is questionable whether the federal agency has authority to permit a policy that would otherwise violate federal law.

At the present time, the announcement means that no child on MA will be subject to co-pays for MA covered services. Affected families will receive a new notice once DPW reaches a decision about future premiums or co-pays. Parents whose income was incorrect on the notice they received in recent weeks can try to get the income corrected by calling the Call Center 1-877-395-8930 (residents of Philadelphia should call 215-560-7226. Parents can also file appeals in order to make sure the income is corrected. Parents should remember that they have 30 days from the date on their notice to file an appeal.

We will continue to update readers about any developments in upcoming newsletters.

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New West Health Choices Zone Now In Effect

Approximately 125,000 Medical Assistance (MA) recipients living in northwestern Pennsylvania are now enrolled in the mandatory managed care program known as HealthChoices. MA consumers living in Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren counties are now part of the **New West Zone** that began October 1st. These individuals must receive their health care services through one of the four managed care plans operating in that zone: **Amerihealth Mercy, Coventry Cares, Gateway Health Plan** and **UPMC for You.** ACCESS Plus and United Healthcare Community Plan (which had been a voluntary managed care plan) ended in this zone on September 30th.

Almost 40% of affected consumers in the New West Zone enrolled in a plan of their choice. The remaining 60% were auto-assigned equally among the four plans available. The percentage of people who chose a plan in the New West Zone was higher than the 25% of consumers who chose a plan in seven south-central counties during the first phase of HealthChoices expansion in July. However, advocates are concerned that despite additional outreach efforts, the majority of MA consumers affected by HealthChoices expansion are not actively making a choice. Instead, they are allowing themselves to be auto-assigned to a plan that may or may not meet their needs. There is heightened concern in the New West Zone because in 5 of the 11 counties that have hospitals, the hospitals are only contracting with 2 of the 4 available plans. This raises potential access problems for consumers who are auto-assigned to plans that do not have contracts with their local hospital. In addition, physicians and other health care providers may be unwilling to contract with plans that do not have a contract with the local hospital.

MA consumers in the New West Zone who are in a managed care plan are able to change their plan at any time by contacting PA Enrollment Services at 1-800-440-3989. Individuals can also change their primary care physician (PCP) at any time by calling their managed care plan. Finally, plans are required to allow their members to continue receiving services from out-of-network doctors in certain situations under continuity of care rules (see the next page for more information about this).

As a reminder, certain MA consumers remain in MA fee-for-service (use the ACCESS card) and are not part of HealthChoices. These consumers currently include: dual eligibles, Aging Waiver recipients, LIFE Program participants, Nursing Home residents (who have been in the nursing home longer than 30 days), HIPP Participants (MA consumers who are also enrolled in employer-sponsored health insurance for which MA is paying the premium), and women enrolled in the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program.

In March 2013, HealthChoices will reach its final phase of expansion with the inclusion of the New East Zone. Over 200,000 MA consumers in 22 counties in Northeastern PA will be impacted and will have to enroll in one of the three plans available in this zone: AmeriHealth Mercy Health Plan, Coventry Cares, and Geisinger Health Plan. DPW plans to send mailings to impacted consumers in mid-January 2013.

Individuals in the New West Zone with questions or problems accessing care should call our Helpline at 1-800-274-3258.

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MA Consumers Moving into a Managed Care Plan Have Continued Care Rights

Under Department of Public Welfare (DPW) policy, Medical Assistance (MA) consumers transitioning from ACCESS Plus to managed care have the right to continue an ongoing course of treatment for a temporary period of time, even if their treating provider is **not** part of the new managed care plan's network. This "**continuity of care**" protection is especially important as DPW expands managed care programs across the state (see the previous page). The continuity of care policy aims to ease the transition when MA consumers have to change delivery systems (i.e., going from ACCESS Plus to managed care or changing managed care plans). The DPW policy, found at MA Bulletin 99-03-13, distinguishes between child and adult consumers and between care that requires prior authorization and care which does not, in terms of individuals' right to access services from certain providers after their MA coverage changes.

A special protection exists for pregnant women, who are entitled to continue receiving services from their existing OB-GYN even if that provider is out of network under their new managed care plan. This protection extends throughout a woman's pregnancy and includes the delivery and post-partum period (60 days after giving birth) .

Children

For prior authorized care for a child under the age of 21, a new managed care plan **may not** change, reduce, or terminate that care during the approved time period; prior authorized services must be honored by the new plan until the authorization period ends (regardless of who granted the previous authorization).

The treating provider should notify the new managed care plan of the prior authorization and the provider and plan should come to mutually acceptable rate terms. The treating provider does not have to join the managed care plan's provider network to continue the course of treatment.

For a course of treatment provided to a child **not** requiring prior authorization, a new managed care plan must ensure continuation, without interruption, for up to 60 days from the date of enrollment into the new plan. The treatment can continue past 60 days if the provider and managed care plan determine it is clinically appropriate. Again, the provider should contact the new managed care plan to let them know about the child's continued course of treatment.

Adults

For prior authorized care for an adult MA consumer, a new managed care plan must either:

(1) approve the care and honor the earlier prior authorization in full for up to 60 days, or
(2) approve the care pending a concurrent clinical review of the service at issue.

The new managed care plan **may not** reduce, delay, or interrupt services pending its own clinical review. If the new plan's concurrent review results in reduced or stopped services, the plan must provide advance written notice of its decision and honor the consumer's right to exercise grievance

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and fair hearing rights. If the consumer files an appeal within ten days of the adverse action, s/he has the right to have the service continued at the previously authorized level during the appeal process.

For a course of treatment provided to an adult not requiring prior authorization, the continuity of care policy is the same as for children. The new managed care plan must ensure continuation, without interruption, for up to 60 days from the date of enrollment into the new plan. In both situations (prior authorized services or services that are part of a continued course of treatment), providers should contact the individual's plan to work out the details about coverage of ongoing services.

The MA Bulletin detailing the continuity of care rules can be found at www.dpw.state.pa.us under "Bulletin Search". We encourage individuals who joined a new managed care plan recently and who are having trouble accessing services or providers to contact our Helpline at 1-800-274-3258.

OLTL Selects a Statewide Financial Management Services (FMS) Vendor

The Office of Long-Term Living (OLTL) recently announced the selection of Public Partnerships, LLC as the sole Financial Management Service (FMS) provider across Pennsylvania for certain individuals receiving services through the OLTL administered Waiver programs (Aging, Attendant Care, CommCare, Independence, and OBRA). Participants in these waiver programs who choose to use the consumer-directed model for their services (where they choose, hire, train and fire their attendants) get FMS to help with the administrative tasks of writing pay checks, paying required taxes, etc.

Starting in January 2013, current Waiver recipients using the consumer directed model will transition to the new vendor for FMS services. Notices were sent out at the beginning of October notifying them of this change. OLTL is working with Public Partnerships, LLC on the "roll out" plan so that consumers will have a smooth transition to their new FMS provider. New Waiver consumers can start to use Public Partnerships, LLC as their FMS provider as of October 1st.

In recent months, current waiver recipients directing their own services have experienced problems with FMS services. A number of providers stopped providing services on July 1st, and as a result, 1,700 waiver recipients were moved to a new FMS provider. Since the change, there have been problems with caregivers/attendants not being paid or receiving incorrect payments. OLTL is working to ensure these problems are corrected so that the caregivers affected receive accurate and timely paychecks. OLTL recently reported that of the 1,600 complaints they received regarding timely and/or correct payment for caregivers, all but 240 have been resolved.

Attendants working under the consumer-directed model are encouraged to review their paystubs to ensure their pay is correct and that their withheld local taxes are going to the correct municipality (or county) at the correct rate. Any discrepancies should be reported to the FMS agency immediately.

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Medicare Annual Open Enrollment Starts October 15th!

All Medicare beneficiaries can make changes to their Medicare Advantage plan or their Medicare prescription drug plan during the **Open Enrollment Period** which **starts October 15th** and **ends December 7th.** Any changes made by a beneficiary during this period will become effective on January 1, 2013. Medicare beneficiaries should have already received their 2013 Medicare and You Handbook, which includes information about all available plans in 2013.

In Pennsylvania, Medicare beneficiaries continue to have many Prescription Drug Plan and Medicare Advantage Plan options available. For 2013, Medicare has approved 38 Prescription Drug Plans, 14 of which are zero-premium for dual eligibles and other individuals receiving the full low-income subsidy (see the Medicare publications at www.phlp.org for a listing of 2013 zero-premium plans). Every county has Medicare Advantage Plan options; choices range from a low of 17 plans in Bradford County to a high of 48 plans in Berks County. In most counties, Medicare beneficiaries can choose from among 20-30 plan offerings. Next year, all but two counties (Bradford and Franklin) will have at least one Special Needs Plan for full dual eligibles (people that have Medicare and full Medical Assistance).

In addition to the Medicare and You Handbook, individuals can find information about plan choices in 2013 on Medicare's official website, www.medicare.gov. Medicare Plans have already sent out information to current members about next year's plan benefits. **Everyone on Medicare should review that information as well as their plan options to decide if they should remain in their current plan or change plans in 2013**. Individuals who need help during the Open Enrollment Period can contact APPRISE at 1-800-783-7067 or Medicare at 1-800-633-4227.

Medicare Announces 2013 Part D Costs

Medicare recently announced the standard cost-sharing for 2013 Medicare Part D Plans. Part D plans that offer **standard** benefits use this cost-sharing for its members. Part D plans that offer **alternative or enhanced** benefits must assure their coverage is actuarially equivalent to the standard benefits.

In addition to the Part D plan premium, beneficiaries who do not qualify for a subsidy will pay the following for a 2013 standard Part D Plan:

- An annual deductible of **$325** (up from $320 in 2012);
- During the initial coverage period, a 25% co-pay for each prescription until the consumer's total drug costs reach **$2,970** (up from $2,930 in 2012);
- During the coverage gap (also referred to as the "doughnut hole"), a percentage of the costs of drugs (in 2013, 47.5% of the cost of brand name drugs and 79% for generic drugs plus a small dispensing fee) until the consumer's total out-of-pocket expenses reach **$4,750*** (this figure was $4,700 for 2012); and
- During the catastrophic coverage period, a co-pay of **$2.65** for generics and **$6.60** for name-brand drugs, or a 5% co-pay, **whichever is greater** (the current co-pays are $2.60 and $6.50).

*Not all of the costs consumers pay during the donut hole count toward total out of pocket expenses.

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More information about the 2013 Medicare Part D coverage costs can be found by contacting 1-800-MEDICARE (1-800-633-4227).

Costs for Individuals Receiving the Low-Income Subsidy (LIS) or "Extra Help"

In 2013, the low-income subsidy (LIS) benchmark premium for Pennsylvania will be $36.57. This is the maximum amount LIS will pay toward a Part D plan premium for someone with a full subsidy who is in a standard Part D plan. Next year, there are 14 stand-alone prescription drug plans that will not have a premium for members who receive the full subsidy (see www.phlp.org for a list of these plans).

People who qualify for the **full subsidy** in 2013 will pay the following small co-pays for their Part D medications (depending on their income):

- $1.15 generics/$3.50 brand name; or
- $2.65 generics/$6.60 brand name; or
- $0 if someone is a full dual eligible (has Medicare and full Medicaid coverage) and is receiving long term care services in a nursing home or through a Home and Community-Based Services Waiver program.

Individuals who qualify for a **partial subsidy** in 2013 will pay the following:

- An annual deductible reduced to $66;
- A 15% co-pay for their drugs once the deductible is met until they spend $4,750 out-of-pocket;
- Co-pays of $2.65/generics and $6.60/brand name drugs for the rest of the year.

Please note: *there is no coverage gap or "doughnut hole" for people who receive any level of subsidy.*

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

When you get your PHLP newsletters by e-mail, you can:

- Print as many copies as you'd like
- Share your newsletter with family, friends, and coworkers
- Save your newsletter for later, without worrying that it will get lost in a pile of papers

If you'd like to switch to e-mail newsletters, contact staff@phlp.org and let us know!

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Human Services Block Grant Update

Twenty counties have been selected to participate in the Human Services Block Grant pilot program. The approved counties are: Allegheny, Beaver, Berks, Bucks, Butler, Centre, Chester, Crawford, Dauphin, Delaware, Erie, Franklin, Fulton, Greene, Lancaster, Lehigh, Luzerne, Tioga, Venango, and Wayne. Ten additional counties applied to participate in the pilot program, but were not chosen (Cambria, Columbia, Lackawanna, McKean, Northampton, Potter, Schuylkill, Warren, Washington, and Westmoreland).

As discussed in previous newsletters, the block grant pilot program was included as part of the final budget bill (Act 80 of 2012) that passed earlier this year. The Block Grant consolidates several human services line items such as mental health services, intellectual disability services and drug and alcohol services, among others, into a single funding source. The 20 counties selected for this pilot program will need to decide how to use the funding they receive from DPW.

The Department of Public Welfare (DPW) requires each county participating in the pilot to:

- Hold two public hearings before submitting detailed plans to DPW for how their block grant funds will be allocated.
- Submit an annual report to the Senate Public Health and Welfare and the House Human Services Committees on how the Block Grant is being used.
- Observe limitations on how block grant funds are expended for child welfare services, including congregate care and institutional placements for dependent and delinquent children.

Other Block Grant Developments

On September 27, 2012 Representative Jerry Knowles (representing parts of Berks and Schuylkill counties) circulated a memo seeking co-sponsors for legislation to "amend Act 80 of 2012 to expand the Human Services Block Grant Program to at least 30 counties with the amendment to take effect immediately." Representative Knowles cites "the level of interest clearly evidenced by the number of applicants" as his rationale for expanding the number of counties able to participate in the Block Grant. According to his memo, the proposed legislation would give the 10 counties not chosen the opportunity to ask DPW for reconsideration. If any of those counties choose not to request reconsideration, other counties can submit an initial request to participate in the program.

While Representative Knowles seeks to expand the Block Grant Pilot Program, others have filed a lawsuit to stop it. On October 1, 2012, the Disability Rights Network of Pennsylvania (DRN), together with Community Legal Services (CLS) and private co-counsel, filed a lawsuit in Pennsylvania Commonwealth Court to challenge the constitutionality of Act 80 of 2012. The lawsuit contends that the General Assembly disregarded procedural protections in enacting the law without opportunity for required debate and consideration. Act 80 also eliminated General Assistance cash benefits effective August 1, 2012 and the lawsuit also challenges this legislative action. The petitioners are requesting a Preliminary Injunction to stop DPW from implementing Act 80. DRN represents several associations and organizations in the lawsuit. The lawsuit and press release can be viewed at:

http://drnpa.org/drn-files-lawsuit-to-challenge-constitutionality-of-act-80-of-2012/

PHLP will update readers on continuing developments with the Human Services Block Grant implementation, and the lawsuit, in future newsletters.

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Reminder: Adult Children Can Receive Coverage under a Parent's Health Insurance through Age 29

Pennsylvania law allows adult children to continue receiving coverage under their parent's health insurance policy until their 30th birthday. This law (Act 4 of 2009) is **not** related to the Affordable Care Act provision that allows adult children to be covered under their parent's insurance until the age of 26. Many of PHLP's Helpline callers seem familiar with the Affordable Care Act provision but are unaware of PA Act 4 of 2009, so we wanted to remind our readers about this state law.

Act 4 requires insurance companies to provide an option for extending coverage under group health plans for adult children of enrollees. To be eligible, the adult child must be:

- 29 years of age or younger;
- unmarried;
- without dependents;
- a Pennsylvania resident or enrolled as a full-time student at an institution of higher education; and
- have no other health insurance (including Medical Assistance).

Act 4 does not require employers to offer the coverage to their employees. The Act only requires the insurer to offer this option to employers who allow employees' children to be covered under the employer's group plan.

Parents who elect to keep adult children on their policy will be responsible for paying all additional premiums that apply for the continued coverage as employers are not required to contribute to any premium increase.

The extension of coverage does **not** apply to the following types of insurance coverage:

- individual health plans;
- self-insured or self-funded health plans
- hospital indemnity, accident; specified disease, disability, dental or vision insurance;
- insurance provided by the U.S. military;
- Medicare supplemental insurance;
- long term care policies; and
- other limited benefit plans.

Parents covered through their employers' group health plan who are interested in exploring this option for their adult children should contact the Human Resource Department at their place of work.

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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Attention: Medicare Part D Consumers, Providers, and Advocates

PHLP is conducting free trainings to educate low-income consumers, providers, and advocates about upcoming changes to Medicare Part D in 2013.

Come to a training to learn more about:

- 2013 Part D Plan Costs and Options;
- changes to the definition of Part D covered drugs (to include benzodiazepines and certain barbiturates);
- review of enrollment periods and notices consumers receive in the fall; and
- other developments affecting low-income Medicare beneficiaries (such as, Medicaid changes affecting dual eligibles).

There will be four in-person training sessions in Southwestern PA. **To RSVP please e-mail staff@phlp.org or call our Helpline at 1-800-274-3258.**

Monday, October 29th, 2012 9 am-11 am Presbyterian Senior Care Hillsview Chapel 835 S. Main St. Washington, PA 15301	**Tuesday, October 30th, 2012** 9 am-11 am Mental Health Association Conference Room 140 N. Elm St. Butler, PA 16001-4820
Wednesday, October 31st, 2012 9:30 am-11:30 am Westmoreland County Area Agency on Aging Conference Room 200 S. Main St. Greensburg, PA 15601	**Friday, November 2nd, 2012** 9:30 am-11:30 am Allegheny General Hospital Lecture Hall 320 E. North Ave. Pittsburgh, PA 15212

For individuals unable to attend one of the in-person sessions listed above, PHLP will offer webinar trainings on **Tuesday, November 13th** from 9:30 am to 11:30 am and **Thursday, November 15th** from 1 pm-3 pm. To register for a webinar, please use the appropriate link below.

Tuesday, November 13th, 9:30 am to 11:30 am

Registration URL: https://attendee.gotowebinar.com/register/1360820807095043328

Thursday, November 15th, 1 pm-3 pm

Registration URL: https://attendee.gotowebinar.com/register/6987092175169025792

Please share this announcement with others who may be interested in attending one of our trainings.

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Pennsylvania's Progress on the Affordable Care Act

Pennsylvania appears to have made little forward progress in building a Health Insurance Exchange as part of the Affordable Care Act. Pennsylvania must make a decision on the type of Exchange it will utilize by November 16, 2012. Based on publicly available information, Pennsylvania does not appear to be ready to meet the criteria put forward by the Department of Health and Human Services (HHS) in its Blueprint for Approval of Affordable State-based and State partnership Insurance Exchanges issued August 13, 2012.

State administrators continue to seek additional guidance from HHS on a variety of issues. Although reports have been commissioned and completed, the Department of Insurance has not made decisions regarding the Essential Health Benefits that will be offered through plans on the Exchange.

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