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Medicaid Reinstatement Possible for 100,000

Approximately 100,000 individuals who lost Medical Assistance (MA) benefits in the last year for failure to provide verification information were recently sent a letter from the Department of Public Welfare (DPW) telling them how they may seek expedited reinstatement of their benefits. These letters (printed on **blue** paper) were sent in late October and early November as part of a settlement reached between DPW and Community Legal Services along with its law firm partner Morgan, Lewis & Bockius LLP.

As readers may recall, in July 2011 DPW announced it would be sending out redetermination packets to thousands of individuals who were overdue for a redetermination. During the last six months of 2011, legal service offices and community agencies saw a significant increase in individuals losing their MA due to a failure to return renewal forms and required verification.

A very simple 2-page form is included with the blue letters. Individuals have **30 days** to fill out the form and send it back to DPW along with:

- Pay stubs if anyone in the household works, and
- Unpaid medical bills incurred during the time they didn't have Medical Assistance **or** receipts from medical bills paid during this time.

The form and supporting documentation should NOT be returned to a local County Assistance Office because all reinstatement forms will be reviewed in a central location. Instead, the form should be returned in the envelope provided. **Decisions on eligibility will be made within 30 days unless more information is needed.**

The letters provide phone numbers to local legal aid programs for individuals who have questions or concerns about this process. Other advocacy organizations can expect to see individuals coming to them with questions or seeking help with this process. A sample blue letter and reinstatement form, along with more information about this project, can be found on the Community Legal Services website at: http://www.clsphila.org/NewsItem.aspx?id=279.

INSIDE THIS EDITION

Overview of Medicare Plan Choices

Medicare beneficiaries in Pennsylvania continue to have many plan choices when it comes to Medicare Prescription Drug Plans and Medicare Advantage Plans. In 2013, there are 38 stand-alone prescription drug plans available to Medicare beneficiaries across PA. Our Medicare Part D region (which also includes West Virginia) has the highest number of stand-alone drug plans available nationally for the second year in a row. Of these 38 plans, 14 are "zero-premium" for people who qualify for the full Low-Income Subsidy.

PA isn't losing any "zero-premium" plans for full subsidy recipients between this year and next year; however, the current Community CCRx Basic, CVS Caremark Value, and Health Net Orange Option 1 plans which are all zero-premium will be combined next year into one plan called SilverScript Basic. Also, the current Medco Medicare Prescription Drug Plan-Value will be going by a new name in 2013- Express Scripts Medicare-Value. There will be four new zero-premium plans available in 2013- Reader's Digest Value Rx, SecureAdvantage Rx-Option 1, SmartD Rx Saver, and AARP MedicareRx Saver Plus. The list of 2013 zero-premium plans is available on PHLP's website at www.phlp.org.

Medicare Advantage Plans

Medicare Advantage is the term for Medicare managed care where individuals can join a private plan that contracts with Medicare to provide its members with their Medicare coverage. Medicare managed care plans may cover prescription drugs, but there are plan options available that do not provide this coverage. Next year, each county in Pennsylvania has Medicare Advantage Plan options available. Bradford County offers the fewest number of Medicare Advantage plans (17) and Berks County offers the highest number of Plans (48). Most counties have between 30-40 Medicare Advantage plans available.

Special Needs Plans for Dual Eligibles

Special Needs Plans (SNPs) are a subset of Medicare Advantage plans that can limit their enrollment to certain groups of Medicare beneficiaries. There are Special Needs Plans for dual eligibles (D-SNPs) that generally require someone to have full Medical Assistance (MA) coverage in addition to their Medicare in order to join. Other types of Special Needs Plans are Institutional SNPs (for people receiving long-term services in a nursing home or in the community) and Chronic Care SNPs (for people who have certain conditions specified by the plan such as diabetes or congestive heart failure).

All counties in PA except for Bradford and Franklin County will offer dual eligibles at least one D-SNP plan option in 2013. There are some notable changes regarding these plans in 2013:

- **UPMC for Life Specialty Plan** (currently available throughout most counties in Western PA) is terminating at the end of the year. Members have already received written notification that

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the plan will end 12/31/2012. Individuals who do not take action to join another plan by the end of December will revert back to Original Medicare (red, white, and blue card) and be auto-enrolled into a zero-premium prescription drug plan by Medicare effective January 1st.

UPMC currently offers another D-SNP called **UPMC For You Advantage** that will continue in 2013 in a number of counties across the state. This plan is similar to the Specialty plan in that it is available in the same counties, has the same provider network, and offers the same benefits (with some extra coverage for dental and vision services). Medicare did not permit UPMC to tell consumers about this other plan option available in the termination notice that was sent. Instead, UPMC has been attempting to contact members to alert them of the UPMC for You Advantage plan option. Individuals who are losing the UPMC for Life Specialty Plan can contact UPMC directly to enroll in the UPMC for You Advantage Plan. Individuals who join the UPMC for You Advantage plan by the end of December will be enrolled for January 1, 2013.

- **Gateway Health Plan** is offering a new plan for duals in addition to their current plan, Gateway Medicare Assured. This new plan, **Gateway Medicare Assured 3**, is available to dual eligibles whose only benefit through Medicaid is having their Medicare Part B premium paid (as opposed to getting full benefits through MA). To our knowledge, this is the first D-SNP that offers coverage to those who only get these limited benefits through MA. Individuals can contact Gateway Health Plan to get information about this new plan.

- HealthAmerica is offering a new plan in many counties across the state called **Advantra Cares**. This D-SNP is being offered in counties where there have not been D-SNP options previously, or where there may have only been one other D-SNP available.

- Vista Health Plan will offer two new D-SNP plans in Eastern PA. The plans are called **AmeriHealth VIP Care** and **Keystone VIP Choice**. Both AmeriHealth and Keystone have had D-SNPs in the past, but the previous AmeriHealth 65 plan for duals ended in 2008 and the previous Keystone 65 plan for duals ended in 2009.

In addition to the plans noted above, other D-SNP options continue to be available in 2013 including: Bravo-HealthSpring Select, Bravo-HealthSpring Silver, Geisinger Gold Secure 1, Security Blue Care, and UnitedHealthcare Dual Complete.

Individuals who want to find out what plans are available in their county (Prescription Drug Plans, Medicare Advantage, and Special Needs Plans) can contact 1-800-MEDICARE or visit www.medicare.gov. Contact information for all 2013 plans can also be found in the Medicare & You 2013 Handbook sent to all Medicare beneficiaries in recent months.

Medicare Open Enrollment Period: Time to Compare Plan Options and Make Changes

Medicare's Annual Open Enrollment Period has been underway since October 15th and will end December 7th. All Medicare beneficiaries can add (or drop) drug coverage during this period and/or change their Medicare health or drug plans. After this period ends, individuals are only allowed to make changes to their health and/or drug plans if they qualify for a Special Enrollment Period (dual eligibles and people receiving the low-income subsidy/extra help qualify for an ongoing Special Enrollment Period and can change their plans at **any** time during the year).

It is important that all Medicare beneficiaries review their current plan as well as their 2013 plan options to determine whether their best choice is to stay with the plan they have or to switch to a different plan. Here are some factors to consider when comparing plan options:

- **Costs**: What does the plan charge for a premium? Is there a deductible? What are the co-pays for medications, for other services? How much will my drugs cost in the doughnut hole?

  ***Please note**: if you qualify for a low-income subsidy, you will not be subject to the plan's costs for prescription drugs. Your subsidy will limit how much you pay for drugs under any plan you join. You can contact Medicare for more information about what your costs will be with your subsidy.*

- **Coverage**: Are the drugs I take covered on the plan's formulary? Does the plan have any special rules for coverage of my drugs such as requiring Prior Authorization, Step Therapy, or Quantity Limits?

- **Pharmacy network**: Can I continue to go to my local pharmacy to get my medications? What are the plan's mail order options? Does the plan have "preferred" pharmacies and, if so, are what are the cost-sharing differences between these and non-preferred pharmacies?

- **Provider Network** (if considering a Medicare Advantage Plan)-Are all the health care providers I see or use in the plan's network? Does the plan have any rules for how I access care (i.e., do I need a referral to see a specialist?)

Individuals who need help comparing plans or learning about plan options for next year can call Medicare (1-800-633-4227), APPRISE (1-800-783-7067), or PHLP, if dual eligible, (1-800-274-3258). People can also research plan options on www.medicare.gov.

Medicare Part D Prescription Coverage Expands in 2013

Effective January 1, 2013, Medicare Part D Plans will expand their drug formularies to include benzodiazepines as well as barbiturates that are prescribed for certain conditions. Up until now, Medicare law excluded benzodiazepines and barbiturates from Medicare Part D coverage. The Affordable Care Act changed the law and expanded Part D coverage to include these medications beginning next year.

Benzodiazepines are anti-anxiety medications such as Ativan, Diazepam and Klonopin. Beginning on January 1st, benzodiazepines will be included as a covered drug class in Part D plan drug formularies. Like with other Part D covered drugs, plans can limit access to these medications by only covering certain benzodiazepines, requiring prior authorizations, imposing quantity limits or through step therapy. Barbiturates are a class of drugs that act as depressants to the central nervous system and include medications such as Phenobarbital and Amytal Sodium. Under the Affordable Care Act, barbiturates must be covered by Part D plans if they are used in the treatment of cancer, epilepsy and chronic mental health disorders. If barbiturates are being prescribed for any other purpose, they continue to be excluded from Part D coverage.

Full dual eligibles (those with Medicare and full coverage through Medicaid) can currently use their Medicaid ACCESS card at the pharmacy to cover prescriptions for benzodiazepines and barbiturates that are now excluded from Medicare Part D coverage. Beginning on January 1st, that will no longer be the case. Because Part D plans can now cover these medications, the ACCESS card will no longer include coverage for benzodiazepines and barbiturates used for treatment of cancer, epilepsy and chronic mental health disorders.

When comparing plan options for next year, all Medicare beneficiaries taking benzodiazepines and barbiturates (for the certain conditions listed above) should check that their medications are on the plan's formulary and check to see if there are any special rules for coverage of those medications. Those who have questions about this change or who need help accessing their prescription medications through their Part D plan can call PHLP's Helpline or APPRISE at 1-800-783-7067.

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.

Slight Increase to LIS and MSP Asset Limits for 2013

Effective January 1, 2013, the asset limits 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. 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 LIS through the Social Security Administration and apply for MSP through the PA Department of Public Welfare/County Assistance Offices.

Part D Low-Income Subsidy (LIS):

LIS asset limits in 2013 will be:

- **Full Subsidy-$7,080 for a single person and $10,620 for a married couple**
  (these limits are currently $6,940/single person and $10,410/married couple)
- **Partial Subsidy-$11,800 for a single person and $23,580 for a married couple**
  (these limits are currently $11,570/single person and $23,120/ married couple).

Please note that the asset limits shown above are *after* all deductions and disregards are taken, including the $1,500 per person disregard the Social Security Administration gives if someone plans to use their assets for funeral or burial expenses.

In addition to asset limits, these programs also have income limits. Individuals must have income below 135% FPL to qualify for a ***full*** subsidy (currently $1,257/mo for a single person and $1,703/mo for a married couple) and below 150% FPL to qualify for a ***partial*** subsidy (currently $1,396/mo for a single person and $1,891/mo for a married couple). The income limits may change in 2013 after updated Federal Poverty Guidelines are released (usually late January or February).

Medicare Savings Programs (MSP)

Federal law requires MSP asset limits to match the asset limits for the full Low-Income Subsidy. Therefore, **in 2013, the MSP asset limits will be $7,080 for a single person and $10,620 for a married couple**. Again, these amounts are after all deductions and disregards are taken.

The current MSP asset limits are $6,940 (single) and $10,410 (married couple). In addition to meeting the asset limit, a beneficiary's income must be below 135% FPL to qualify for MSP.

Please contact PHLP's Helpline with questions about qualifying for either LIS or MSP.

OLTL Selects Statewide FMS Vendor

Starting in January 2013, Public Partnerships, LLC will be the sole Financial Management Service (FMS) provider across Pennsylvania for certain individuals receiving services through waivers administered by the Office of Long Term Living (OLTL)–the Aging, Attendant Care, CommCare, Independence, and OBRA waivers. Participants in these waiver programs who 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.

Current Waiver recipients receiving FMS will transition to the new vendor for FMS services in January. OLTL sent notices at the beginning of October about this change to current Waiver recipients receiving FMS. The state is working with Public Partnerships, LLC on the "roll out" plan so that consumers will have a smooth transition in January. As of October, waiver consumers who have never received FMS before and who recently started to use the consumer-directed model have the option of using Public Partnerships, LLC as their FMS provider.

As we reported in our last newsletter, current waiver recipients directing their own services have experienced problems with FMS services in recent months. A number of providers stopped 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 1,700 complaints they received regarding timely and/or correct payment for caregivers, all but 90 have been resolved. Attendants who are not receiving their correct pay should report this to the FMS agency immediately.

Final Part in Dual Eligible Series: Partial Duals

Each month through our Helpline, PHLP talks to individuals (or to their family members, advocates or 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 obtain only limited coverage through Medicaid such as having Medicaid pay for their Part B premium).*

This series reviews what happens when someone becomes a dual eligible and what, if any, actions they need to take. Our April 2012 Senior Health News (available at www.phlp.org) discussed individuals receiving full Medicaid coverage who ***then*** *become eligible for Medicare. Our August 2012 newsletter discussed individuals on Medicare who later become eligible for full Medicaid.*

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(Continued from Page 7) This final piece in the series discusses ***partial dual eligibles***. Partial dual eligibles are people that have Medicare and who receive limited benefits through Medicaid (called Medical Assistance or "MA" in Pennsylvania). Often, the only benefit partial dual eligibles get is MA payment of their monthly Part B premium-known as the Medicare Savings Programs or "buy-in". The MA programs that provide only this help are called Specified Low-Income Medicare Beneficiary (SLMB) and Qualified Individual (QI-1). Individuals receiving the buy-in no longer have their Medicare Part B premium deducted from their Social Security benefit check.

Other partial duals could have **limited** coverage through an MA ACCESS card; however, this ACCESS card does **not** provide full MA coverage. It might only cover Medicare Parts A and B cost-sharing (if someone is a Qualified Medicare Beneficiary or QMB) or some other limited benefits (if eligible for MA based on a 6 month spend-down). Here is what partial duals need to know:

- **Most partial dual eligibles who only have coverage through Original Medicare are responsible for paying Medicare cost-sharing**—All Medicare beneficiaries have a choice about how they receive their Medicare benefits (Original Medicare or a Medicare Advantage Plan). Individuals who receive their Medicare coverage through Original Medicare (red, white, and blue card) and have no other health coverage could have significant out of pocket costs for the services they receive. There are Part A and B deductibles and Medicare only covers physical health services at 80% once the deductible is met. Outpatient behavioral health treatment is only covered at 60% (this coverage will increase to 65% in 2013 and then 80% in 2014).

  Action Needed: Since her MA coverage is limited, unless a partial dual eligible is receiving QMB benefits which covers the cost-sharing for services covered by Medicare Parts A and B, she should consider buying a Medigap or Medicare Supplemental Insurance plan that will provide secondary coverage to Medicare. An alternative would be joining a Medicare Advantage Plan as a way to try and control out-of-pocket costs for services. Another reason partial dual eligibles may want to consider joining a Medicare Advantage plan is to obtain supplemental benefits such as dental or vision coverage.

- **Partial 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. The full subsidy helps pay for the Part D plan's premium (and may cover the entire cost if someone is enrolled in a zero-premium plan—see www.phlp.org for a list of these plans). With the full subsidy, dual eligibles will not have to meet a Part D deductible and they are not subject to the Part D "doughnut hole". Instead, they 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 co-pay amounts charged depends on someone's income.

  Action Needed: None. Partial duals should automatically receive this extra help from Medicare without needing to do anything; however, dual eligibles who are being charged higher amounts at

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(Continued from Page 8) the pharmacy than those listed should contact 1-800-MEDICARE or PHLP's Helpline for help because there may be a problem with the subsidy.

- **Partial dual eligibles should join a Medicare Part D plan:** Since partial dual eligibles automatically qualify for the full low-income subsidy, they should join a Part D plan so that they can benefit from that subsidy.

  Action Needed: Partial dual eligibles should join a Medicare Part D plan (either a stand-alone drug plan if they have Original Medicare or a Medicare Advantage Plan with drug coverage) unless they are receiving creditable coverage through a current employer or a retiree plan that does not allow members to join Part D. 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's Helpline.

  Even if partial dual eligibles have coverage through PACE/PACENET or the VA, they should consider joining a Part D plan since their co-pays with the full subsidy will be lower than the co-pays charged by these programs. Partial dual eligibles who are over 65, should also apply to PACE/PACENET as a back-up drug coverage in case some of their medications are not covered by their Part D plan.

  Partial dual eligibles who are currently in Original Medicare and who do not take action to join a plan on their own will be enrolled into a zero-premium stand-alone drug plan by Medicare. These individuals will receive a notice on green paper from Medicare telling them which plan they are being enrolled into and when coverage will start. Partial dual eligibles in Original Medicare who need to have their prescriptions refilled before Part D coverage takes effect can use LI NET (the back-up Part D plan for all dual eligibles and others who qualify for a low-income subsidy). The pharmacy can call 1-800-783-1307 for information about how to bill LI NET.

  Note: Partial dual eligibles enrolled in Medicare Advantage plan without drug coverage will be enrolled into a Medicare Advantage Plan with drug coverage through the same organization. These individuals will receive written notice from their Medicare Advantage plan telling them about the change in coverage and when the new coverage will start.

  Partial dual eligibles can opt out of these auto-enrollments by Medicare or their Medicare Advantage plan OR choose to join a different plan. **All** dual eligibles can change their Medicare health or drug plan at any time during the year because they qualify for an ongoing Special Enrollment Period. If a partial dual eligible changes plans, the new plan will be effective the first of the month after they enroll.

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