Health Law PA News

Newsletter of the Pennsylvania Health Law Project
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Governor Signs "Cover All Kids" Legislation
Law Will Make Health Insurance Available to Most Kids in Pennsylvania

The Governor has signed House Bill 2699, which will expand eligibility for subsidized CHIP, increase subsidies for CHIP, and allow many who do not qualify for subsidized CHIP to purchase it at cost. Free Chip will be available for those children who do not qualify for Medical Assistance if their family income is below 200% of the federal income poverty limit. Currently, that amount is $40,000 for a family of 4. There is no resource (asset) test under CHIP. The following subsidies are available for children between 200% and 300% of the poverty level:

- 200% to 250% - 75% subsidy
- 250% to 275% - 65% subsidy
- 275% to 300% - 60% subsidy

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Logisticare Replacing MTM for MATP Services in Philadelphia beginning December 1

Logisticare Solutions is replacing MTM as the Medical Assistance Transportation (MATP) contractor in Philadelphia. Logisticare will start taking reservations for rides on November 20, 2006 for any rides occurring on December 1, 2006 and after.

Logisticare will require 3 days advance notice for paratransit rides and they will continue to provide SEPTA passes in advance for clients. Logisticare has increased mileage reimbursement to .44/mile. For late rides, Lo-

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State auto-enrolls CRDP and SPBP members into Part D Plans

In September, the State enrolled Medicare beneficiaries in the Chronic Renal Disease Program (CRDP) and in the Special Pharmaceutical Benefits Program (SPBP) into one of 9 Medicare Part D plans that are currently partnering with the State. The State only intended to auto-enroll individuals who had not joined a Part D plan on their own although some others slipped through. The State enrolled consumers in plans based on the medications they take (that are covered by these two programs) and the pharmacy they use. In early September, both programs sent letters out to individuals who were to be auto-enrolled into Part D plans. These letters told members which Part D plan they were being enrolled into. In most cases, this coverage started October 1, 2006. For these individuals, Medicare Part D will be their primary prescription drug coverage and the CRDP or SPBP will be their secondary prescription drug coverage.

CRDP and Auto-Enrollment into Part D

The Chronic Renal Disease Program (CRDP) is run by the Department of Health and covers medications related to an individual's renal disease. For members of this Program who were auto-enrolled into Part D, CRDP will pay the Part D plan premium. In addition, the CRDP will help pay the Part D plan costs for drugs that are currently covered by the Program so that members do not pay more than $6/$9 for these drugs. If the Part D plan charges less for these medications, then the individual will pay the lower amount. If an individual is taking drugs

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Medicare Special Needs Plans making changes for 2007

In 2006, many dual eligibles were passively enrolled into Medicare HMOs (also known as Medicare Advantage plans) specially designed for dual eligible consumers. These plans are referred to as Special Needs Plans or SNPs, by Medicare. Consumers who were auto-enrolled into a SNP could get out of the plan and get back into Original Medicare. PHLP and Community Legal Services filed a class-action lawsuit on behalf of beneficiaries who were passively enrolled into SNPs, which was settled this past summer.

In 2007, the number of dual eligible SNPs in Pennsylvania is increasing from 6 plans to 10 plans. Additionally, many of the existing plans are changing the extra benefits that they offer to consumers. For example, Keystone 65, which is available in Southeastern Pennsylvania, had offered a dental benefit to members in 2006. Dental care is not generally available to Medicare beneficiaries though it is available to Medical Assistance consumers. In 2007, Keystone 65 will not offer a dental benefit.

Other plans are adding benefits. In 2006, Unison Advantage, a SNP in Southwestern PA did not offer any additional dental coverage. It offered an additional $500 in hearing aid coverage. In 2007, it will offer oral exams, cleanings and x rays to its members, along with higher hearing aid coverage. UPMC for Life did not offer any additional hearing or vision benefits in 2006 but will offer dental, hearing, and vision benefits in 2007.

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DPW to Pay for Mobile Mental Health Treatment (MMHT)

In September 2005, a group of interested stakeholders convened with DPW's Office of Mental Health and Substance Abuse Services (OMHSAS), to develop guidelines for Mobile Mental Health Treatment (MMHT). In December 2005, DPW submitted State Plan Amendments to the Centers for Medicare and Medicaid Services (CMS) for approval to include MMHT as a MA compensable rehabilitative service. With the approval of CMS, MMHT will be available and MA payable for eligible adults 21 years and older in both the Fee-For-Service and HealthChoices Behavioral Health Program delivery system. This is especially good news for seniors on MA, as the elderly are at high risk for depression, other mental health disorders, and suicide.

The Older Adult Committee of the OMHSAS Advisory Committee identified the need for this service. MMHT will provide an array of services for adults and older adults who have barriers to, or have been unsuccessful with, traditional outpatient mental health treatment. The array of services provided include: evaluations; individual, family or group therapy; and medication visits. These services are provided to consumers in their home or in a community setting of their choice such as a senior center or church.

Adults and older adults must meet certain criteria to be eligible to receive Mobile Mental Health Treatment. To receive these services, individuals must:

- be eligible for MA

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Part D Open Enrollment Period Starts November 15, 2006—Do you need to change your Part D Plan?

The Medicare Part D Open Enrollment Period begins November 15, 2006 and ends December 31, 2006. During this six-week period, consumers who already have Part D will be able to change their plans and join a new plan for coverage effective January 1, 2007. For most people on Medicare Part D, this Open Enrollment Period is the only time during the year to make changes to their Medicare Part D coverage. Remember, people with both Medicare and Medical Assistance (including those that just get their Part B premium paid for by the State) have an ongoing Special Election Period and they can change their plan at any time during the year.

Part D plans are required to send Annual Notice of Change (ANOC) documents to members by October 31, 2006 that explain how the plan's benefits and costs will change for 2007**. It is very important that members read this information so they can decide whether that plan will continue to meet their needs or whether they need to change plans for 2007.** If they are not sure whether they received this information, or if they are unclear about how plan's benefits are changing in 2007, they should call their plan for more information.

Here are some questions people should consider when deciding whether to change Part D plans in 2007:

- Will the Plan still cover my drugs in 2007?
- Will the plan have any special rules for my drugs (i.e., prior authorization,

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OMHSAS Reviews County Plans and Performance Measures; Counties Receive Financial Awards

Every fiscal year, the County Offices of Mental Health Services are required to submit a mental health plan detailing what mental health services and supports are needed in their county and the dollar amounts needed to provide those services. The County Mental Health Plans for fiscal year 2007-'08 were due to the state Office of Mental Health and Substance Abuse Services (OMHSAS) in the spring of 2006. Well in advance of that due date, all counties received a letter from OMHSAS Deputy Secretary Joan Erney outlining the administrative and quality performance measures that were to be evaluated regarding the '07 – '08 plans. Counties were also informed that financial awards were being provided to counties as an incentive to meet the performance measures.

Deputy Secretary Erney identified two performance measures; an Administrative Measure and a Quality Measure. The Administrative Measure was the timely, accurate and complete submission of the required Consolidated Community Reporting Performance Outcome Management System (CCR POMS) data. The first two quarters to be measured were July 2005 to September 2005 and October 2005 to December 2005. The Quality Measure was tied to the 2007-'08 County Plan Guidelines. The measure was a requirement to include a Vision & Mission Statement that supports the facilitation of recovery of individuals with mental illness and required evidence of consumer involvement in the development of the plan and concurrence with the Vision & Mission Statement.

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Loophole Premium Waiver withdrawn

Estelle Richman, the Secretary of the Department of Public Welfare announced on October 31, 2006 that the state is withdrawing its plans to impose a monthly premium for Medical Assistance coverage for children with disabilities under the loophole.

Children who are severely disabled are entitled to Medical Assistance regardless of their parent's income. During budget negotiations last year, DPW had announced plans to seek a waiver from the Centers for Medicare and Medicaid Services to allow DPW to charge a sliding scale monthly premium to families with children with disabilities whose incomes were above a certain amount. The amount of the premium would have depended on family size and income and ranged from $0 to $1000 per month. DPW has withdrawn the request for the waiver from CMS.

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gisticare will have 5 vehicles that they can dispatch to pick up consumers.

Logisticare will have an office in Philadelphia located at 520 N. Delaware Avenue, Suite 801. To make ride reservations or other information, call Logisticare at 1-877-835-7412.

Existing MATP riders should have received a welcome letter and a brochure in the mail from Logisticare. If consumers are registering with MATP for the first time, the brochure will be mailed after the registration.

For complaints about Logisticare, call 1-877-835-7428. All complaints submitted in writing will receive a written response.

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Nursing Home Transition is underway

The Department of Public Welfare's Nursing Home Transition teams have expanded statewide. The transition teams assist nursing home residents in moving back into the community and started as a four county demonstration project.

The Nursing Home Transition has two methods of moving consumers into the community. The "Side door" identifies individuals in nursing homes who could live in the community. The residents are provided with education and assistance in transitioning to the community. Approximately 474 individuals were transitioned out of nursing homes from January 2005 to August 2006. One of the biggest barriers to transitioning out of a nursing home is lack of available housing.

The second method of transitioning people out of nursing homes is via the "Front Door," where new nursing home admissions are targeted. This population is assessed by the AAAs and counseled regarding their options.

Money Back for BCCPT consumers!

Medical Assistance beneficiaries who are covered through the Breast and Cervical Cancer Prevention and Treatment Program (BCCPT) will be receiving refunds for all co-payments they paid since March 31, 2006. The Budget Reconciliation Act of 2005, allowing states to make cuts in Medicaid ser-

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PHLP Protests the 1-800-MEDICARE shut down for dual eligibles

The Pennsylvania Health Law Project has protested the decision by the Centers for Medicare and Medicaid Services (CMS) to shut down dual eligible enrollment into Medicare Part D Prescription Drug Plans over the 1-800-MEDICARE line and the website, www.medicare.gov. Until January 1, 2007, dual eligibles and others with a Special Election Period are not able to use these two established methods of enrollment into a Part D plan to change plans or enroll in Medicare Part D. Instead consumers can only change plans or enroll for 2006 by contacting the plan they have decided to enroll in.

Dual eligibles are entitled by law to change their prescription drug plan at anytime. Other Medicare Part D consumers are locked into their plan for the year and can only change plans during the Open Enrollment Period, November 15 to December 31, with changes effective January 1, 2007. Medicare decided to shut down enrollment via the 1-800-MEDICARE number and the website to changes effective before January 1, 2007 to reduce confusion. However, this has created additional confusion for dual eligibles and for new Medicare beneficiaries who are not able to use the preferred methods to change, especially since plans have been unwilling to implement pre-2007 changes.

The Pennsylvania Health Law Project, sent a letter to Medicare Administrator Leslie Norwalk protesting the shutdown and demanding that the line and

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ACCESS Plus Regional Advisory Committee to Meet in 4 Locations

ACCESS Plus is the Medical Assistance program operating in 42 non-HealthChoices counties, that integrates primary care case management with disease management. It serves approximately 280,000 persons in the fee-for-service system. McKesson Corporation is the state's contractor for Access Plus, and Automated Health Systems (AHS) of Pittsburgh is the subcontractor which oversees the primary care case management.

AHS' responsibilities include helping enrollees locate a primary care provider; assisting enrollees with scheduling appointments for both preventive and primary care services; matching enrollees to specialist services; coordinating care, including arranging transportation, locating physical and behavioral health providers, and arranging for services for enrollees with special needs.

McKesson employs disease management programs with respect to Asthma, Diabetes, Chronic Obstructive Pulmonary Disorder, Coronary Artery Disease and Heart Failure Programs. Disease management includes: regular calls from or face-to-face contact with a registered nurse to help with chronic illness management; teaching new ways to self-manage the chronic illness, sharing new information on the chronic illness; and 24 hour access to a nurse advice hotline.

AccessPlus members, especially those who have issues to raise concerning the accessibility of health care services, are invited to participate in their local quar-

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The outcomes were measured using a point system. Four points was the maximum number awarded. There were 3 possible points for the Administrative Measure, one point for timeliness, one point for accuracy and one point for completeness of the CCR POMS data. There was one possible point for the Quality Measure regarding the Vision and Mission Statement. A review committee comprised of consumers, family members, providers, advocates, state employees and representatives of the OMHSAS Advisory Committee evaluated each county's compliance with this measure.

Each point earned was awarded $23,810 to the county. Of the total counties and county joinders, 9 were awarded 4 points for a total of $95,237. Of the remaining counties, 4 were awarded 3 points, 6 were awarded 2 points, 24 were awarded 1 point and 5 counties received no points. Those interested in learning the specific awards for each county can access that information on the County MH/MR Administrators website at www.pa.counties.org/mhmr/lib/mhmr/county_planning_awards.pdf. Counties have been instructed by OMHSAS that the award monies are to be used for mental health services or supports identified as needs in the county plans. Mental health consumers and family members are encouraged to follow up with their county administrators to have input in deciding how these dollars will be used.

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Currently, the cost to purchase CHIP is $143 per child per month. Based on this figure, the monthly premium payment for CHIP for any child qualifying for a 75% subsidy will be $36 per month, for a 65% subsidy will be $50 per child, and for a 60% subsidy will be $57 per child.

The Insurance Department has been granted authority to set increased co-payments for certain CHIP services, and intends to permit co-payments below.

For families with income between 200% and 300% of the federal poverty guideline:

- $5.00 for a primary care physician visit
- $10.00 for a specialist visit
- $25.00 for an emergency room visit if not admitted
- $9.00 for a bran name prescription drug and $6.00 for a generic

For families with income above 300% of the federal poverty guideline:

- $15.00 for a primary care physician visit
- $25.00 for a specialist visit
- $50.00 for an emergency room visit if not admitted
- $18.00 for a brand name prescription drug and $10.00 for a generic

In order to discourage employers from dropping health insurance, no child in a family with income above 200% of the poverty level will qualify for CHIP unless they have been without health insurance for 6 months. This rule will not apply to children under the age of 2 (subject to CMS approval), or where the parent is eligible for unemployment compensation, or where the parent is not eligible for unemployment compensation but had health insurance and is no longer employed. The rule will also not apply if a child is transferring from one government subsidized health care program (i.e. Medical Assistance) to another.

In order for a family with income above 300% of the federal poverty level to qualify to purchase CHIP, the family must show either that: 1) purchasing individual or group coverage would exceed 10% of the family income, or 2) the total cost of coverage would exceed 150% of the CHIP premium, or 3) the family has been refused coverage due to a pre-existing condition.

The law gives the state the right to purchase coverage from an individual's employer rather than CHIP if the insurance meets minimum coverage requirements and the Insurance Department determines that it would be more cost effective.

The new law will be effective 30 days following publication of a notice in the Pennsylvania Bulletin, or on January 1, 2007, whichever is later The CHIP law sunsets on December 31, 2010.

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- be age 21 or older ***– and-***

- have a documented medical or psychiatric condition that precludes them from participating in mental health outpatient clinic services ***- or -***

have one or more significant and documented psychosocial stressors that precludes them from participating in mental health outpatient clinic services ***– and -***

- agree to participate in MMHT as prescribed

These services have not yet been authorized by CMS but OMHSAS reports that it looks positive and they are hopeful for CMS approval in the next month.

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that are not covered by the CRDP, they will have to pay the costs that their Part D plan charges for those medications.

Individuals who already had Part D coverage (either through a stand-alone prescription drug plan or Medicare Advantage Plan) or who had other creditable prescription drug coverage (i.e., a retiree/employer/union sponsored plan) should NOT have received the auto-enrollment letter and should not have been auto-enrolled into a Part D Plan by the CRDP. However, PHLP has heard from a number of consumers (and dialysis social workers) about problems with the auto-enrollment. In an effort to identify and correct any problems, the CRDP is sending a letter to members. A Question & Answer document is also being drafted to provide more information about how these two programs will work together.

SPBP and Auto-Enrollment into Part D

The Special Pharmaceutical Benefits Program (SPBP) is run by the Department of Public Welfare and covers medications for HIV/AIDS and schizophrenia. The SPBP will pay the Part D plan premium for members who were auto-enrolled into plans. The SPBP will also help pay the cost of Part D for drugs that are covered by the SPBP. This means that an individual will not pay more under Part D than they currently pay under SPBP for medications that are covered by the program. If an individual is taking medications that are not covered by the SPBP, they will be subject to their Part D plan costs for those medications.

SPBP members who already had Part D coverage (either through a stand-alone Prescription Drug Plan or through a Medicare Advantage Plan) or who have other creditable prescription drug coverage should NOT have been auto-enrolled into Part D by SPBP.

If you have any experienced any problems as a result of this auto-enrollment, please call the PA Health Law Project HELPLINE at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

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vices, also included this small bonus – women eligible under BCCPT are exempt from co-pays. The consumer sub-committee of the Medical Assistance Advisory Committee urged the Pennsylvania Department of Public Welfare to facilitate refunds directly to consumers and DPW has accepted the recommendation.

The Department will go through claims forms and identify all persons in the BCCPT program who had visits to providers that required co-pay. Unless the provider indicated that the co-pay was waived, the consumer will receive a refund from DPW. Consumers who receive refunds will be told that if the provider did not collect the co-pay, then the consumer owes that co-pay to the provider.

Women covered under the BCCPT program should no longer owe any co-pays for any Medical Assistance visits. Approximately 1000 women across the state are covered under this program.

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terly Regional Advisory Committee (RAC) meetings. The next regularly scheduled meetings, which are held from 11:30 to 1:30, will occur on the following schedule:
December 5 at Clarks Summit; December 7 at Johnstown; December 12 at Erie; and December 14 at State College.

Interested consumers should call 1-800-543-7633 or visit the ACCESS Plus Program website at www.accessplus.org. for more information.

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quantity limits, or step therapy)?
- Is my pharmacy still in the plan's network?
- How have the costs of my plan changed? Can I still afford this plan?
- Am I satisfied with the plan's customer service? When I have questions, concerns or problems, am I satisfied with the way the plan handles them?

Other questions to ask if you are deciding whether to stay in a Medicare Advantage plan or if you are deciding whether to switch to this type of plan include:
- Are my doctors/hospital/psychiatrist/ other medical providers in the network in 2007?
- Are there any new rules for how I access care in 2007 (i.e., will I need a referral from a primary care provider to see a specialist?)
- Has coverage of medical benefits changed in any way (i.e., has the plan dropped coverage for hearing exams/ hearing aids)? If so, will my needs still be met?

What to Do If You Decide To Change Plans

Remember, consumers have until December 31, 2006 to make any changes for the upcoming year. **Medicare is encouraging people to make changes by December 8, 2006** to make sure coverage in the new plan starts on January 1, 2006. This will give both Medicare and the plans time to process applications and send information to consumers about their new coverage.

Individuals can change plans the following ways:
- Contact the plan you want to join directly
- Contact 1-800-MEDICARE (1-800-633-4227 or 1-877-486-2048 (TTY))
- Enroll in new plan online at www.medicare.gov (after November 15, 2006)

Individuals who change plans during this Open Enrollment Period will be disenrolled from their current plan as of 12/31/06 and their new coverage will start 1/1/06. Enrolling in a new plan automatically disenrolls someone from their current plan.

If you have questions about Part D plan choices in 2007 or if you need help finding plans that may meet your needs, you can contact 1-800-MEDICARE (1-800-633-4227 or 1-877-486-2048, TTY) or the APPRISE Program at 1-800-783-7067.

If you are a dual eligible and you have questions about your Part D plan choices or how your insurance coverage works, please contact the PA Health Law Project HELPLINE at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

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If you are in a Special Needs Plan, PHLP urges you to examine your current benefit and what changes will occur before you decide whether you want to stay in that plan, switch to a different plan, or switch to Original Medicare.

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website be re-opened for enrollment in 2006. A copy of the letter can be seen on the PHLP website, www.phlp.org. No response has been received yet. Other advocacy groups have also protested CMS' action.

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PHLP Thanks The Philadelphia Foundation for it's Generous Support

PHLP is pleased to announce the recent receipt of a $17,500 grant from the Alice H. and Joseph W. Campbell Fund #1, and the William J. McCahan 3rd Fund in Memory of Thomas C. McCahan and Florence M. McCahan, of The Philadelphia Foundation in general operating support of our efforts to ensure equal access to quality health care for low-income families and the working poor in Southeastern Pennsylvania. As Southeastern Pennsylvania's primary provider of philanthropic services, The Philadelphia Foundation manages more than 750 charitable funds established by caring families who want to give something back to their community. Revenue generated from these funds provides grants and scholarships to over 1,000 cultural, educational and humanitarian programs, exactly as the donors intended. The Philadelphia Foundation was one of PHLP's earliest supporters in the 1980s, and without their support, PHLP would not be here. Thank you!

PHLP staff are available in Southwestern and Southeastern PA to conduct trainings on Part D to help social service agencies and their clients navigate the Part D system. Trainings focus on the rights that dual eligibles have under Part D and the appeals and grievance processes that are available to all Part D enrollees. To learn how to help get your clients' needs met through Medicare Part D, contact the PHLP HELPLINE to schedule a training (1-800-274-3258 voice or 1-866-236-6310 TTY). Please let us know if you require any special accommodations for persons with hearing and/or vision needs.

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