SENIOR HEALTH NEWS

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Assisted Living Proposed Regulations Coming Soon!

A lot has been happening with Assisted Living in Pennsylvania! Specifically, since our last issue we want to report on how the regulations continue to develop and on the work that the PA Assisted Living Consumer Alliance (PALCA) has begun.

Regulations Update

The Department of Public Welfare's Assisted Living Workgroup met for the last time in April. The Workgroup, which includes stakeholders representing consumers as well as providers, has met regularly with state officials to provide input on the development of the draft regulations. Workgroup members have reviewed preliminary drafts of the proposed regulations and have submitted comments to recommend certain changes and improvements to the draft regulations. The Department has circulated a final draft of the proposed regulations that it anticipates will be published by the end of May in the PA Bulletin. A 30-day public comment period will follow publication of the proposed regulations. If you are interested in following the regulations' progress, we encourage you to join the mailing list of the PA Assisted Living Consumer Alliance (see below).

PALCA Update

The PA Assisted Living Consumer Alliance (PALCA) was created earlier this year to make sure that the consumer voice gets heard in the development of Assisted Living Regulations for Pennsylvania. The Consumer Alliance is a coalition of organizations committed to ensuring quality assisted living options for consumers. **Consumers and consumer advocates are encouraged to join the Alliance and may do so by contacting Alissa Halperin at ahalperin@phlp.org.**

The group meets regularly (both in-person and by phone) and discusses critical issues consumers want to have appropriately addressed in the new regulations. Such critical issues include:

1) what residents rights must be articulated;
2) what discharge and appeal rights consumers should have;
3) what services consumers should expect to receive;
4) what freedom consumers should have to use their own healthcare and supportive service providers;
5) who must assess needs, develop support plans, and oversee that services are provided as desired and required;
6) how public funds should be spent to enable lower-income consumers to reside in assisted living; and
7) what staff people should provide which care and in what amounts.

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Suggestions and recommendations of the Alliance have been shared with the members of the Assisted Living Workgroup representing consumers. The Alliance will continue to monitor the regulation development process and will be commenting on the proposed regulations when they are issued to make sure that the proposed regulations address areas of concern to consumers and include sufficient consumer protections.

In addition to meeting to discuss various issues related to the development of the regulations, the Alliance has requested membership into the National Assisted Living Consumer Alliance to draw on the expertise of this group. The Alliance will soon launch a website and is developing position papers on various Assisted Living issues of importance to consumers.

If you are interested in learning more about the Alliance, please contact Alissa Halperin at ahalperin@phlp.org. We will keep you posted about the Assisted Living Proposed Regulations and about the PA Assisted Living Consumer Alliance's progress in upcoming newsletters.

The Impact of Economic Stimulus Payments on Eligibility for Public Health Programs

Some low-income consumers may be eligible for the economic stimulus payments currently being sent to qualified individuals. Consumers who received at least $3,000 in 2007 income from sources such as Social Security (retirement, survivor, and disability benefits) or the Veterans Administration (VA) can qualify if they file a 2007 tax return by **October 15, 2008**. The deadline to qualify for a stimulus payment has been extended beyond April 15, 2008 because of concerns that many eligible consumers who do not usually have to file tax returns were unaware of the need to file a tax return in order to get the payment. Qualified individuals will receive payments between $300 and $600.

Those who receive the economic stimulus payment will want to understand how the payment will affect eligibility for public healthcare programs. The short answer is that the payment will not immediately affect eligibility for Medical Assistance (MA), the Medicare Part D Low-Income Subsidy (LIS), or PACE/PACENET.

The rebate check will not be treated as countable *income* for MA, the LIS, or PACE/PACENET.

The rebate check might be treated as a countable *resource* for MA or the LIS **if and only if** the rebate is unspent by the end of the 2nd month following receipt of the rebate. For example, if an individual gets a rebate payment in May 2008, and decides to keep it or invest it, it would not count as a resource for May, June, or July 2008. If any funds remain unspent after July 31, 2008, then the amount remaining would be counted as a resource and may affect someone's eligibility for MA and the LIS. Countable resources include such things as money in bank accounts, investments, and cash at home or elsewhere. The PACE/PACENET programs do not consider resources when determining eligibility, so this will not be an issue for PACE/PACENET members.

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MA Now Requires "Tamper Proof" Rx

As of April 1, 2008, all written prescriptions for Medical Assistance (MA) recipients in the Fee-for-Service (FFS) system (i.e., who use the ACCESS card) must be written on "tamper proof" prescription pads. This is required by federal law.

The new rules apply to **all** outpatient prescriptions covered by MA FFS regardless of whether MA is the primary or secondary payer for the prescription. The rules **do not** apply in the following situations:

- Prescriptions that are covered through a MA managed care plan.
- Prescriptions written in institutions like nursing homes or intermediate care facilities for the mentally retarded;
- Refills of prescriptions when the original prescription was written before October 1, 2007 (unless the person was not on MA at the time).
- Prescriptions transmitted to a pharmacy by telephone, fax, or electronic transmission. (*Note*: electronically printed prescriptions must be printed on tamper proof paper).

Pharmacies will be permitted to dispense an emergency supply of a medication, consistent with MA law, as long as a verbal, faxed, electronic, or tamper-proof prescription is provided to the pharmacy within 72 hours. This applies to all MA covered prescriptions except controlled substances (Schedule II narcotics) for which Pennsylvania law requires a written prescription at the time of dispensing.

If a consumer presents a prescription at a pharmacy that is not tamper proof, the pharmacist should call the prescribing physician and accept a telephone prescription. Individuals having problems getting medications because of these new rules can call the PHLP Helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

LIS Ended April 1st for Some Medicare Consumers

Last month, the Social Security Administration (SSA) sent notice to approximately 3,300 individuals in PA who lost their Part D low-income subsidy (LIS) effective April 1, 2008. The notices were sent to individuals who:

1) were found eligible for the LIS by SSA, and
2) were picked for redetermination by SSA in fall 2007, and
3) failed to provide the requested redetermination paperwork to SSA or respond to subsequent follow-up attempts.

In 2007, SSA's LIS redetermination process changed from the previous year and all LIS recipients selected for redetermination return paperwork even if their situation had not changed.

Affected individuals have a 3-month Special Enrollment Period (starting April 1, 2008) to enroll in a different plan. These individuals should have received information from their Part D plan about their new premium and co-pay amounts without the LIS. Individuals who lost their LIS on April 1st can always reapply for the LIS. As a reminder, the current LIS guidelines are:

Full Subsidy

Individual: Income less than $1,170/month ($14,040/year); Resources less than $7,790.
Married Couple: Income less than $1,575/month ($18,900/year); Resources less than $12,440.

Partial Subsidy

Individual: Income less than $1,300/month ($15,600/year); Resources less than $11,990.
Married Couple: Income less than $1,750/month ($21,000/year); Resources less than $23,970.

Call PHLP's Helpline if you lost your LIS on April 1, 2008 and have questions or need assistance (1-800-274-3258 or 1-866-236-6310/TTY).

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Overview of Aging Waiver Care Plan Review Process

The Department of Aging's current care plan review process is under review and may soon be overhauled. We wanted to provide an overview of the current care plan review process to help people understand it better and to identify some of the problems encountered by consumers.

The care plan process begins with staff from the local Area Agency on Aging (AAA) meeting with Aging Waiver applicants or recipients and their caregivers to do an assessment of the waiver services needed to allow the individual to remain living in the community. The AAA staff person completes a proposed care plan for the consumer. If the proposed care plan includes services that cost less than $55/day and there is space available in the waiver program at that time, then the care plan can be implemented and services can begin as soon as they can be arranged.

If the consumer's proposed care plan includes services that cost more than $55/day, then the AAA staff submits a request for a care plan review by the Department of Aging. If the services cost between $55-119.99, a temporary care plan of services costing less than $55 is initiated (as long as the consumer can be served safely at this level of service and as long as waiver slots are available). A review is then done of the proposed permanent care plan as described below. Any proposed care plan that involves services costing more than $119.99 per day are sent directly to the Department of Aging for review and no temporary care plan is implemented for the applicant.

Care plans with services over $55/day are reviewed first by Quality and Compliance (Q&C) Specialists at the Department of Aging. These individuals review the requests and have a care plan review conference where they may call the local AAA if clarification is needed for the review. Factors such as the consumer's medical condition, medical need, physical environment, and informal support structure are considered. If the Q&C Specialists approve the care plan and if the approved cost is less than $90/day, then the AAA is notified of the approval and services can begin (if waiver slots are available). If the Q&C Specialists review the care plan and approve a care plan with services that cost over $90/day, then the case is referred to a Harrisburg Review Committee for final approval. The Harrisburg Review Committee then notifies the local AAA of their decision.

In counties that have Community Choice (the expedited application process for individuals at imminent risk for placement in an institution), there is an expedited review process in place for consumers at risk of placement in a nursing home within 5 days.

PHLP has heard complaints that the current process presents a disincentive to caregivers to propose services that cost more than $55/day. We have heard about lengthy delays as a result of this care plan review process, especially with those reviews that need final approval by the Harrisburg Review Committee. Often, as well, the $55/day temporary care plan is wholly inadequate to meet the needs of the individual.

Any final decision about the amount of services approved in the final care plan can be appealed and a Fair Hearing can be requested. PHLP may be able to assist in these appeals. Please contact our HELPLINE (1-800-274-3258) for additional information about the care plan review process or if you need assistance with the appeal process. The directive about the current care plan review process can be viewed at: http://www.aging.state.pa.us/aging/lib/aging/APD-06-01-03.pdf.

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Special Billing Issues for Dual Eligibles: Review of Dual Eligible Protections

In recent months, PHLP has been getting a high volume of helpline calls from dual eligible individuals (people who get both Medicare and Medical Assistance (MA)) about billing problems regarding the Medicare cost-sharing amounts. Therefore, we wanted to review the dual eligible protections included in the law to help consumers and their family members prevent and/or resolve billing problems and help them avoid making unnecessary payments to providers.

First and foremost, it is against the law for a Medicare provider to bill a dual eligible for Medicare cost-sharing. This is true even if the Medicare provider does not accept Medical Assistance. All dual eligible consumers need to show their ACCESS card along with their Medicare card (either the red, white, and blue card or a Medicare Advantage plan identification card) ***each time*** they receive services. The ACCESS card that dual eligibles will show to the providers will either be yellow (if they only get Medical Assistance) or green (if they get food stamp benefits in addition to their Medical Assistance). A provider can refuse to treat an individual if the provider does not take the ACCESS card; however, if the provider treats the individual, he cannot bill her for ***any*** Medicare cost-sharing. Providers are not allowed to accept dual eligibles as "private pay" in order to bill the consumer directly.

The provider bills Medicare (or a Medicare managed care plan like a Special Needs Plan or SNP) first and bills any remaining balance to Medical Assistance (MA). MA is always the payer of last resort, which means that after the provider bills Medicare, MA will be responsible for covering any amounts not covered by Medicare, such as deductibles and co-insurances normally charged to Medicare consumers who do not have any other insurance.

Providers must accept payment from MA as payment in full. In general, MA pays up to the applicable MA fee schedule amount for the service provided, so Medicare providers may not receive payment for the entire amount of Medicare cost-sharing from MA. Sometimes, the provider may receive no additional payment from MA beyond what Medicare paid. Nonetheless, providers cannot bill dual eligibles for any of the Medicare cost-sharing or the remaining balance after both Medicare and MA pay (this is called "balance billing" and it is not allowed). Providers who bill dual eligibles for the Medicare cost-sharing are subject to sanctions.

Dual eligibles who receive a bill from a provider for their Medicare cost-sharing should call or write a letter to the provider to make sure that the provider has their correct insurance information on file and to be sure that the provider is billing both Medicare and MA. They should tell the provider to bill MA for any Medicare cost-sharing if they have not yet done so and give the provider their Recipient Identification number from the ACCESS card if needed. Dual eligibles who are having billing problems can call the PHLP's Helpline at 1-800-274-3258 or 1-866-236-6310 (TTY) for assistance.

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Update on the Renewal of Aging Waiver

As we reported in the last Senior Health News, Pennsylvania's current Aging Waiver expires at the end of June 2008. In order to continue the waiver, the State had to apply to the Centers for Medicare & Medicaid Services (CMS) for renewal of the Aging Waiver for another 5 years. After holding Listening Sessions around the state earlier this year and reviewing the comments and input obtained during those sessions, the Office of Long Term Living (OLTL) submitted the waiver renewal application to CMS at the end of March 2008. This document can be viewed at: http://www.dpw.state.pa.us/About/OLTL/.

One of the major areas of concern addressed at the Listening Sessions was the final federal rules to implement provisions of the Deficit Reduction Act addressing "targeted case management". These new regulations would require a substantial overhaul in how the waiver is currently administered and how consumer's care is overseen. The state originally feared that the waiver renewal would have to address how the new targeted case management requirements would be met. Further, because the targeted case management requirements are complicated and could not be implemented by the end of June, the state worried that the renewal of the Aging Waiver could be held up.

CMS has recently clarified that states will have until May 2010 to come into compliance with the new targeted case management rules. The state will begin to address how to comply with these new federal rules over the next two years. Stay tuned to future newsletters for developments about targeted case management services under MA and the HCBS waivers.

The state hopes to obtain approval of its application to renew the Aging waiver by the end of June 2008.

NFCE Issue Update

For over a year, PHLP and Community Legal Services (CLS) have been pressing the state to return to a lawful definition of nursing facility clinical eligibility (NFCE). Being determined NFCE is the level of care standard one must meet in order to be functionally or clinically eligible for MA coverage of nursing home care as well as the Aging, Attendant Care, Independence, and COMMCARE Home and Community Based Waiver programs offered as alternatives to nursing home care.

The Area Agencies on Aging (AAAs), which perform the level of care assessments for the above mentioned programs, have been operating under a NFCE standard that requires consumers to have skilled care needs, whereas federal law requires states to provide Medicaid funds to support consumers with **EITHER** skilled care **OR** intermediate care needs.

The state has finally released a draft NFCE clarification and guidance to the field. While it is better than what AAAs currently rely upon, it is not sufficiently clear that the state is agreeing that someone can be determined NFCE if they only have intermediate care needs as opposed to skilled care needs. For example, none of the examples provided in the draft clarification include consumers that do not have regular skilled care needs.

According to the guidance, in order to be determined NFCE, an individual would have to have an illness or condition diagnosed by a physician and require care and services provided under the direction of a physician. This is problematic because physicians are not able, willing, or required to assume such a role. As a result, the inability to obtain such physician involvement would be prevent many consumers from establishing or retaining eligibility for services.

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Can MAWD/HCBS Waiver Recipients Get Payment for Medicare Part B Premiums, Too?

PHLP and other legal services programs across the state have received numerous calls from consumers with Medicare and Medical Assistance who are forced to make a difficult choice. If their income is above a certain level, they must choose between participation in the State's Medicare Savings Program (under which Medical Assistance pays for their Medicare Part B premium, but doesn't pay for health care) and participation in the Medical Assistance for Workers with Disabilities (MAWD) program or in Home and Community Based (HCBS) Waiver programs (without receiving coverage of Part B premiums).

Current DPW policy only allows the payment of Part B premiums for MAWD/HCBS recipients with income below certain limits. Specifically, DPW policy allows for the following:

- **If an individual's income is below 120% of the poverty level** ($1,060/month for 2008) and she is in MAWD or receiving HCBS services through a Waiver, DPW will also pay her Medicare Part B premium.
- **If an individual's income is between 120% and 135%** ($1,060-$1,190/month), she can get either payment of the Part B premium through the Medical Savings Program **or** receive health care benefits through MAWD/HCBS. DPW's policy does not allow for individuals at this income level to qualify for both payment of the Part B premium and MAWD/HCBS at the same time. In situations where someone has been getting payment of the Part B premium prior to enrolling in MAWD or HCBS Waiver, she has to "choose" between continuing to receive payment of the Part B premium or enrolling into MAWD or HCBS Waiver. Similarly, if someone has been receiving MAWD or HCBS Waiver benefits and then becomes eligible for Medicare, she must "choose" between continuing to get the MAWD or HCBS Waiver coverage or getting payment of the Part B premium.
- **If an individual's income is above 135%** ($1,190/mo for 2008) and she is a MAWD or HCBS Waiver consumer, her Medicare Part B premium is not covered under current DPW policy. This is because the income limit to qualify for payment of the Part B premium benefit under the Medicare Savings Program is 135% or less.

PHLP's position is that DPW is misinterpreting federal law, and that all MAWD and HCBS Waiver recipients should have their Part B premiums covered. Our interpretation of federal law is that a Medicare recipient who receives Medical Assistance benefits through MAWD or HCBS Waiver is entitled to full Medicare cost-sharing, including Payment of the Part B premium, as part of the MA benefit package under these categories. We believe that DPW is superimposing requirements of the Medicare Savings Program onto MAWD/HCBS Waiver recipients without any regulatory support. We are interested in hearing from consumers and their advocates about their experience with this issue, are available to represent consumers facing this problem, and encourage people to call our Helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY) to discuss this further.

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The draft clarification was submitted to several advisory committees for review and comment. It is available on the ALERTS page of our website (www.phlp.org). Readers are encouraged to review the document and submit comments to the state by e-mailing Brian Lester at blester@state.pa.us.

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Medicare Beneficiaries Struggle with Part D Costs

While consumers with Part D have continually reported to our toll-free helpline that they are having problems affording their Part D co-payments or costs of medications during the Part D donut hole, two recent studies of Medicare beneficiaries find that the cost of Part D is a problem for beneficiaries across the country.

In one study of Medicare beneficiaries, researchers found that while Medicare Part D has helped improve access to medications for beneficiaries who did not previously have drug coverage and has reduced the percentage of consumers who skip meals or forego paying rent to afford their medications, the sickest beneficiaries are still skipping medications because of cost concerns. The other study found that consumers do not fully understand their Part D plan costs. Specifically, consumers sampled were often unaware of the Part D donut hole (unless they had reached the donut hole in previous years). In addition, consumers in the sample reported changing their behavior (switching to a less costly medication or failing to refill a medication) in order to reduce their out-of-pocket costs. Abstracts from the studies can be viewed at: http://jama.ama-assn.org/cgi/content/short/299/16/1922.

Consumers are encouraged to call PHLP's helpline to explore eligibility for programs or procedures to lower their Part D drug costs. PHLP's toll-free Helpline number is 1-800-274-3258 or 1-866-236-6310 (TTY).

Pennsylvania Health Law Project
437 Chestnut St., Suite 900
Philadelphia, PA 19106

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