

Senior Health News



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1-800-274-3258 / 1-866-236-6310 TTY

PACE + Medicare Begins September 2006

Governor Rendell signed the PACE Plus Medicare Program into law on July 7, 2006. Since then, the PACE program has moved quickly to implement the changes. Under the PACE Plus Medicare program, PACE and PACENET will encourage people to enroll in Part D and will help enrollees with the cost of Part D coverage. The state wants people to enroll in Part D because it will shift costs to the federal government and help the State save money to help more seniors.

Important things to know about this new program and the changes are:

- ? PACE and PACENET will continue to exist,
- ? The same drugs are available through the 9 plans listed below as were available in the past under PACE and PACENET, for the same cost or less, and
- ? Enrollment in Part D is voluntary

PACE/PACENET Enrolling Some Members Into Part D Plans

PACE has partnered with nine Medicare Prescription Drug Plans and has enrolled about half of the current PACE/PACENET enrollees (about 165,000 individuals) into one of these nine plans. The nine plans partnering with PACE/PACENET are: Humana's Standard and Enhanced plans, Ovations' United MedAdvance and AARP MedicareRx plans, MemberHealth Community Rx Basic plan, Highmark's BlueRx Basic Plan, AmeriHealth Advantage's Option 1 plan, First Health's Premier plan and Pacificare's Saver plan.

PACE/PACENET enrollees selected for PACE Plus Medicare got a letter from the program in July telling them which of the 9 plans they would be enrolled in starting September 1. The state tried to match enrollees up with the Part D plan that best met their needs in terms of covering their medications and working with their pharmacy. Those who received this letter had until August 6, 2006 to decline enrollment into Part D or to pick a different Part D plan.

The July letter was not sent to the following groups of PACE/PACENET enrollees:

- ? individuals who are not eligible for Medicare Part D (those who do not have Medicare

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Plans Underway for Year Two of Medicare Part D

Low-income Medicare beneficiaries soon face another barrage of mailings and notices as preparations begin for Year 2 of Medicare Part D.

Low Income Subsidy (“Extra Help”) Recipients

Beneficiaries who applied and were determined eligible for LIS before May, 2006, will get a letter from Social Security, in early September, saying their LIS eligibility is being redetermined. The letter will list the person's income and assets from the previous determination.

If the financial information in the letter is still accurate, consumers do not need to respond. Social Security will verify the information and then redetermine them LIS eligible through the end of 2007 (as long as the income and assets remain under the LIS guidelines).

If the financial information in the letter is no longer accurate, the person must complete an attachment and mail it back to Social Security, or telephone Social Security, within 15 days. Once Social Security receives this response, it will send the person a financial form to be filled out and sent back within 30 days. The person's LIS eligibility will then be redetermined based on the new information submitted. If the person does not send back their financial information in a timely manner, their LIS will be terminated effective 1/1/2007.

* Please note: the letter described will not be sent to those LIS recipients:

- ? who were automatically given the LIS because they are dual eligibles (on Medicare and Medical Assistance). These consumers will get a separate notice (see below)
- ? who were determined LIS eligible **from May 2006 onward**. These persons will have their LIS eligibility automatically extended and will not be redetermined until August, 2007.

Dual Eligibles

Medicare recipients who also receive Medical Assistance (including those who only get help with their Medicare Part B premium) are labeled “dual eligibles” and were automatically deemed eligible for the LIS in 2006. Medicare will also be redetermining their eligibility this Fall. Using data from July 2006 to start this “re-deeming” process.

? Those previously deemed eligible for LIS who were reported by DPW to still be dual eligible in July 2006, will get a letter informing them their LIS eligibility has been “re-deemed” for 2007

? Those previously deemed eligible for LIS who were not reported to be dual eligible in July 2006, will be sent a notice telling them they are no longer deemed LIS eligible (referred to as “un-deeming”). These persons will no longer automatically get the LIS but can then apply for the LIS to see if they qualify based on their income and assets.

PHLP's Pittsburgh Office has scheduled several workshops in Southwestern PA in early September for advocates and providers to review the LIS and dual eligible re-determination processes, notices, etc. There we will share the latest news and developments from Medicare as we all gear up for Medicare Part D Year 2. See the article on page 5 for details and to RSVP for one of the workshops!!

Spousal Impoverishment Rules Hit Persons in Home and Community Based Services Waivers

The State is starting to apply the nursing home “spousal impoverishment” rules to married people in waiver programs. Married persons receiving home and community based waiver services have begun to receive notices about their resources. Until now, these rules have just applied to those in nursing homes. Waiver programs only counted the resources owned by the spouse applying for or on the waiver. Now, the resources of both spouses count, whether they are in the name of one, or the other, or both spouses.

DPW provided guidelines on how it would apply spousal impoverishment laws to married individuals who were in waiver programs on October 1, 2005. Under the rules, up to \$99,540 in “countable” resources (the number for 2006 - it goes up each year) can be set aside for the spouse not in the waiver. Even more can be set aside by those with very low income. Some resources such as the house and car do not count at all. Countable resources include joint and individual savings accounts, retirement accounts of the spouse receiving services, and certain other assets. The amount of countable resources that can be set aside is not counted toward the \$8,000 limit.

Those receiving Waiver services on October 1, 2005, are being asked to complete a Resource Assessment Form. DPW uses this Resource Assessment Form to calculate the total resources owned by the couple. The recipient must document the value of some resources. Those in the Aging waiver can call their Area Agency of Aging for assistance if they are confused by the form. Consumers in the Attendant Care, COMMCARE, Independence or OBRA waivers, can call the program office for assistance. The Resource Assessment Form is not required if one spouse: (1) currently receives or was receiving SSI benefits on October 1, 2005 or (2) currently is a Medicaid recipient or was an active Medicaid recipient on October 1, 2005 and the resources of the married couple are verified to be within Medicaid limits for a couple.

After the CAO determines the amount that can be set aside for the non-waiver spouse, an additional letter is sent describing how this impacts eligibility for waiver services and what steps a person can take to continue to receive Waiver services. Some steps may be: (1) transfer or re-title certain assets to the name of the non-waiver spouse, (2) pre-pay for some weeks or months of services or pay outstanding medical bills, (3) purchase an annuity to earn income for the non-waiver spouse or (4) take other action.

Unless appropriate steps are taken consumers will receive an Advance Notice of Discontinuation (PA 162A) that Medicaid and Waiver benefits will be terminated. Those receiving these notices have appeal rights, and must appeal within 10 days of the date of the notice to continue services pending the outcome. Persons should file an appeal if they disagree with a notice of termination for any of the following reasons: (1) a failure to return the Resource Assessment Form (2) a failure to provide necessary information or failure to verify resources or (3) a determination that the resources are in excess of the resource limits after applying the spousal impoverishment provisions. Persons can request a fair hearing by returning the Request for a Hearing section of the PA 162A notice. Call the PHLP helpline at 1-800-274-3258/ 1-866-236-6310 TTY for free legal assistance in reviewing a denial.

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Part A or Part B)

- ? members of Medicare Advantage Plans (i.e., Medicare HMOs)
- ? individuals who already joined a Part D Plan on their own
- ? individuals in employee retirement plans with drug coverage
- ? individuals who do not currently take any prescription drugs

PACE/PACENET enrollees who are members of a Medicare Advantage Plan or who currently have Part D coverage through a stand-alone Prescription Drug Plan will get information from PACE/PACENET around September 1, explaining how PACE/PACENET will help them with the cost of their current Part D coverage.

How PACE Plus Medicare will work for PACE Enrollees

Those in PACE who were auto-enrolled into a Part D plan for coverage starting September 1, 2006 will not have to pay a Part D plan monthly premium. PACE will cover this cost. Consumers will use both their PACE and Part D cards at the pharmacy and will not have to pay more than their current PACE co-pays (\$6 generic/\$9 brand) for any medication covered by the PACE program. In some cases, consumers may pay less than their PACE co-pays. PACE will cover any Part D plan deductibles and cover the costs of prescriptions for enrollees through the Medicare Part D donut hole (the period of coverage where an individual has to pay 100% of their medication costs). PACE will also pay for medications that are not on an individual's Part D plan's formulary, as long as the medication is covered by PACE.

If a PACE enrollee already has Part D coverage through either a Prescription Drug Plan or a Medicare HMO, PACE will pay up to \$32.54 of their Part D plan premium. PACE will also cover other Part D costs such as deductibles, co-pays and coverage during the donut hole as explained above. Those who don't enroll in Part D will access medications through the PACE card the same way they do now.

How PACE Plus Medicare will work for PACENET Enrollees

Individuals who are in PACENET and who are enrolled into a Part D plan by the PACENET program will have to pay their Part D plan premium. The premiums for the 9 plans partnering with PACE/PACENET range from \$10.14 to \$32.10. The current PACENET deductible (\$40) will be eliminated. Individuals who have both PACENET and Part D will use both cards at the pharmacy and will not have to pay more than their current PACENET co-pays (\$8 generic/\$15 brand) as long as their medication is covered by the PACENET program. In some cases, PACENET enrollees who have both PACENET and Medicare Part D may pay less at the pharmacy. PACENET will cover any Part D plan deductibles and cover the costs of prescriptions for enrollees through the Medicare Part D donut hole (the period of coverage where an individual has to pay 100% of their medication costs). In addition, PACENET will cover medications that are not on an individual's Part D plan's formulary, as long as the medication is currently covered by PACENET.

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PACENET enrollees who already have Part D coverage will continue to pay their Medicare Part D premium. The PACENET deductible will be eliminated. They will receive help from PACENET for other Part D costs such as deductibles, co-pays and coverage during the donut hole as explained above. This help will likely start after September 1, 2006.

Individuals enrolled in PACENET who decline enrollment into Part D will pay a \$32.54 monthly deductible at the pharmacy. The current \$40 deductible will be eliminated.

Other information about PACE Plus Medicare

For more information about PACE Plus Medicare, see the Department of Aging's website: <http://www.aging.state.pa.us/aging/cwp/view.asp?a=293&q=176137>

SW Part D Trainings on Year 2 Developments!!!

PHLP will hold FREE trainings for advocates and providers on new Part D stuff:

Low-income subsidy ("extra help") redeterminations: The process for re-determining eligibility for the low-income subsidy for individuals approved by Social Security and for dual eligibles starts in September. Notices will start going out to consumers in early September, so make sure you know about these processes!

PACE Plus Medicare: PACE enrolled about half of their members into Part D plans for coverage starting September 1, 2006.

<p><u>Pittsburgh—September 8, 2006 (10am-Noon)</u></p> <p>Carnegie Library of Pittsburgh Downtown Meeting Room, 1st Fl. 612 Smithfield Street Pittsburgh, PA 15222</p>	<p><u>Washington, PA-September 8, 2006 (1:30-3:30pm)</u></p> <p>Cameron Wellness Center Meeting Room B 240 Wellness Way Washington, PA 15301</p>
<p><u>Latrobe, PA—September 11, 2006 (1:00-3:00pm)</u></p> <p>Adams Memorial Library Reed Room 1112 Ligonier Street Latrobe, PA 15650</p>	<p><u>Butler, PA—September 14, 2006 (10am-Noon)</u></p> <p>Butler Area Public Library Meeting Room 1 218 N. McKean Street Butler, PA 16001</p>

SAVE YOUR PLACE!!! Please call the PA Health Law Project Helpline to RSVP at 1-800-274-3258 (voice) and 1-866-236-6310 (TTY), or email eguay@phlp.org

Using the Medicare Part D Appeals Process

All Part D plans must offer an appeals process in place to ensure that consumers have access to medically necessary medications. A person can appeal if their Part D plan denies coverage of a medication or charges the wrong amount for a drug.

Seeking a non-formulary drug

Every Medicare Part D Plan uses a restrictive drug formulary (a list of medications that are available to its members). Plans can also have rules that limit when the drugs on their formulary are covered. For example, some Plans require a trial of generic medication before a brand name will be covered. This rule is called step therapy.

Those who need a medication not on their Part D Plan's formulary, or those who need a brand name drug that is subject to step therapy can request an exception from their Plan. Either the consumer or the prescribing doctor can ask the Plan for a "program exception." **Note** that consumers cannot seek exceptions for drugs not covered by Part D such as benzodiazepines, barbiturates, and over-the-counter (OTC) medications.

To get an exception, the prescribing doctor must first give the Plan information about the medical necessity of the medication that is being denied. Doctors can provide this information orally or in writing (depending on the Plan's requirements). In general, the prescriber has to both say and demonstrate the following:

- ? The formulary drugs would NOT be as effective as the non-formulary drug;
- ? The formulary drugs would have an adverse effects on the consumer;
- ? The drugs required to be tried under the Plan's step therapy regimen have been ineffective or caused adverse effects or are likely to have those results, or
- ? the formulary dosage was, or is likely to be, ineffective or will adversely affect the drug's effectiveness or patient compliance.

The Plan has to decide within 72 hours after receiving the information from the doctor. If this timeframe would jeopardize the consumer's life or health or ability to regain maximum function, the consumer or the doctor should request an expedited decision within 24 hours. If the doctor makes this request, the plan must expedite the review.

If the Plan agrees with the doctor that the drug is medically necessary for the consumer, an exception must be granted. The Plan decides what level of co-pay to charge. If the Plan denies the exception, the consumer can pursue the follow levels of appeal:

- 1) Redetermination: The Plan conducts a paper review. The Plan must provide the member or doctor a reasonable opportunity to present evidence and allegations of fact or law, in writing or in person. The Plan has 7 days to make a decision (72 hours in an expedited case).
- 2) Reconsideration: This is done by an Independent Review Entity (IRE) under contract with Medicare. The IRE for Medicare Part D appeals is Maximus. The IRE has 7



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days to make a decision (72 hours in an expedited case).

Note: If a Plan does not decide an exception request within 72 hours, it is considered a denial and the Plan forwards it to the IRE review stage (skipping the Redetermination stage).

If the amount in dispute meets or exceeds the threshold level annually set by Medicare (currently \$110), the consumer can appeal further to:

- 3) an Administrative Law Judge
- 4) Medicare Appeals Council
- 5) Federal Court

Exceptions to a Plan's co-pay structure

Consumers can also request an exception to their Plan's co-pay/tiering structure in order to get a non-preferred drug covered at a lower co-pay level. Many Part D Plans use a "tiering" system to determine the co-pay their members will pay for a particular drug. Under a tiering system the Plan places the drugs it covers on certain levels -for example, tier 1 may be generic preferred drugs, tier 2 name brand preferred drugs, tier 3 name brand non-preferred drugs. Tier 1 would have the lowest copay, tier 2 a higher copay, etc. Some Plans may even have a "specialty tier" in which it places high cost and unique items. Note that a Plan can exclude drugs on this "specialty tier" from the tiering exception process.

Similar to requesting an exception to the Plan's formulary, the consumer (or the prescribing doctor) can request an exception to the Plan's tiered co-pay level. The prescribing doctor must provide an oral or written statement (depending on the Plan) that the "non-preferred" drug is medically necessary because:

- ? the preferred drug would not be as effective for the consumer; *and/or*
- ? the preferred drug would have adverse effects for the consumer

The Plan has 72 hours (24 hours in expedited cases) to make a determination. If the Part D Plan agrees that the non-preferred drug is medically necessary for the consumer, it must grant the exception and the consumer's co-pay for the non-preferred drug is reduced to the "preferred drug" level. If the Plan denies the request, the consumer has the appeal options described above.

For advice and/or assistance with a Part D appeal, contact the PHLP HELPLINE at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

FREE Medicare Rx Drug Trainings in SE and SW PA

PHLP staff are available in Southwestern and Southeastern PA to conduct trainings on Part D to help you help and your clients navigate the Part D system. Trainings focus on the rights of dual eligibles under Part D and the appeals and grievance processes that are available to all Part D enrollees. To learn how to help your clients meet their needs through Medicare Part D, contact the PHLP HELPLINE to schedule a training (1-800-274-3258 voice or 1-866-236-6310 TTY). Let us know if you require special accommodations for hearing or visual needs.

PHLP Launches List serve focusing on dual eligible issues for people over 60 in SE PA

The Pennsylvania Health Law Project has started an e-mail list serve to provide monthly updates on new developments in Medicare and Medical Assistance for the 60+ population in SE Pennsylvania. The list serve will also serve as a forum for advocates to discuss issues around Medical Assistance and Medicare. The list serve is staffed by PHLP with statewide information and discussion, including special attention to the 5 County Philadelphia area. Only individuals who express an interest in being placed on the list serve will be included. If you have any questions or would like to join, please contact Jennifer Nix at jnix@phlp.org. Please include your name, the name of your organization, the population you work with, and your email address. This listserve will be restricted to organizations in the five county Philadelphia area.

Personal Care Homes Appeal Ruling on New Regulations

The personal care home providers who had sued the Department of Public Welfare last year over the new personal care home regulations have appealed the May 2006 Commonwealth Court decision that dismissed the lawsuit against the state. When the lawsuit was dismissed, the injunction that had kept the regulations from being fully enforced was lifted. The regulations are currently being enforced in full. For more information about the lawsuit and the regulations, see last month's edition of the Senior Health News. Residents or advocates needing assistance with filing complaints against a personal care home can contact the Pennsylvania Health Law Project Helpline at 1-800-274-3258 or 1-866-236-6310 TTY.

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