Senior Health News

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Passive Enrollment Leads to Problems for Dual Eligibles

In November, the Pennsylvania Health Law Project and Community Legal Services filed a class action lawsuit against the Center for Medicare and Medicaid Services (CMS) on behalf of all Pennsylvania's dual eligibles who had been in Medical Assistance Managed Care and were passively enrolled into a Medicare HMO without their permission. Since then, many clients have had problems as a result of being passively enrolled—either because they do not want to be in a Medicare HMO or because they are having trouble accessing services or medications from the Medicare HMO. Here are some questions and answers about Passive Enrollment:

1. I was passively enrolled into a Medicare HMO- how do I get out?

All passively enrolled individuals can disenroll from the Medicare HMO they have been put in. You can disenroll and return to your Original Medicare retroactively (back to 1/1/06 or 2/1/06) and at the same time, retroactively enroll into a stand-alone prescription drug plan (PDP). Alternately, you can disenroll from the Medicare HMO by electing a new plan (PDP) to take effect on March 1, 2006. CMS reports that it sent all passively enrolled individuals an individualized notice about these disenrollment options in mid-February.

To disenroll from a Medicare HMO, call 1-800-MEDICARE. Tell them you were passively enrolled and you would like to disenroll. Tell them whether you would like to disenroll back to January 1st or February 1st or if you would like to wait until March 1st. Whatever date you pick, have the name of a plan you want to join or a list of your medications and choice of pharmacy available so the staff at 1-800-MEDICARE can help you choose a prescription drug plan that meets your needs. You will get a confirmation number from Medicare regarding your enrollment into the new prescription drug plan. Keep this information. After a few days you will get a disenrollment confirmation letter. If you have any problems disenrolling from a Medicare HMO, please

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contact the Pennsylvania Health Law Project helpline at 1-800-274-3258.

Once you are disenrolled, you will use your red, white, and blue Medicare card and your Access card to see your medical providers. You will use your new prescription drug plan to get your medications. However, you should continue to use your Medicare HMO card until you receive confirmation of your disenrollment and your new prescription plan identification card.

2. I was passively enrolled into a Medicare HMO and I am having problems getting my medications.

The Medicare HMO you were put in has to cover all medications (without prior authorization or other difficulties) that were covered under your Medical Assistance HMO until March 31, 2006. "Attestations" signed by each Medicare HMO are available on our website at www.phlp.org. Despite these signed promises by each plan, many passively enrolled individuals have had problems getting drugs they were getting under their Medicare HMO. If you have any questions or are having any problems obtaining you medications from your Medicare HMO, call our helpline at 1-800-274-3258.

3. I was passively enrolled into a Medicare HMO and I am having trouble seeing my providers.

The Medicare HMO you were put in must allow you to see all Medicare providers you see, regardless of whether they are in the Medicare HMOs network, at least until March 31, 2006. Again, the Medicare HMO cannot impose any prior authorizations or require you to obtain any referrals to specialists before April 1, 2006. The providers should bill the Medicare HMO. This information is also contained in the "attestations" each of the Medicare HMOs signed, copies of which can be downloaded from our website at www.phlp.org. Despite these signed promises by each plan, many passively enrolled individuals have had problems seeing their healthcare providers under their Medicare HMO. If you have any questions or are having problems accessing your providers, call our helpline at 1-800-274-3258.

4. I thought that I already disenrolled from the Medicare HMO I was passively enrolled in but I am still getting information from them or my doctor says I am still in it..

Try to find out what plan you are in by calling 1-800-MEDICARE or by logging on to www.medicare.gov and clicking on "Personal Plan Finder." You will need to provide information from your red, white, and blue Medicare card. This will show what plan Medicare has you listed in.

If Medicare says that you are enrolled in the Medicare HMO you thought you disenrolled from, tell them again that you want to disenroll from that plan and to enroll in a stand-alone prescription drug plan. You may want to ask for retroactive disenrollment to January 1st or February 1st (see question 1 above). Take notes on the date and name

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of person you spoke with and write down your disenrollment confirmation number.

If Medicare says that you are enrolled in the stand-alone plan you chose, you should have been disenrolled from the Medicare HMO and should be able to disregard the information that you are getting from the Medicare HMO. Unfortunately, not all the computer systems are providing the same information. So, the system your health care providers and pharmacy use may still show you in the Medicare HMO. If this happens, call our helpline at 1-800-274-3258 for assistance.

If Medicare says you are in a completely different plan (neither the Medicare HMO nor the PDP you chose), tell Medicare you want to disenroll and enroll into the PDP you had already selected. If you have questions or need assistance, call our helpline at 1-800-274-3258.

5. If I disenroll from my Medicare HMO, how will I get medications?

Whether you disenroll from your Medicare HMO back to January 1 or February 1 or whether you disenroll effective March 1 (or the first of the next month), you need to pick and enroll in a stand-alone prescription plan to be effective at the same time your disenrollment takes effect.

6. What if I want to stay in the Medicare HMO that I was enrolled into?

If you want to stay in the Medicare HMO you were put in, you don't need to do anything. However, you should make sure that your providers are included in your plan's network and that your medications are on your plans formulary. Also, be sure you understand what referrals or prior authorization requirements you will have to meet to get the healthcare services you need. After March 31, 2006, you can be restricted to the plan's providers, medications, and rules for how to access care.

7. What if I need help?

Many dual eligibles are having trouble getting the care they need or understanding how to get out of the Medicare HMO they were put in—especially those that already tried to get out but find themselves still in. If you have any questions or are having any problems disenrolling from your Medicare HMO or accessing providers or medications, please call our helpline for assistance at 1-800-274-3258.

Share Your Passive Enrollment Story

Go to www.phlp.org and click on the Medicare Prescription Drug Page for a downloadable survey you can complete and return to us. Or call our helpline at 800-274-3258 to complete a survey by phone.

Medicare Prescription Drug Benefit Update

Under the law, dual eligibles could either pick a prescription drug plan or would be automatically assigned to a prescription-only drug plan to use with their Medicare coverage starting on January 1. The goal was to insure that all dual eligibles have drug coverage on January 1. However, when January 1 came around, many dual eligibles were not in a plan at all or had not received information as to what plan they were put in. Many found out they were not in the plan they had signed up to be in. Others had trouble finding out what plan they were in. Many know the name of their plan but had not received a member identification card they could use at the pharmacy. And more. Here are some questions and answers about dual eligibles and enrollment into the stand-alone prescription drug plans (PDPs):

1. How do I know which plan I am in?

You can find out which plan you are enrolled in either by calling 1-800-MEDICARE or by logging on to www.medicare.gov and following the link "Compare Medicare Prescription Drug Plans" to the link for "Find a Prescription Drug Plan." The site will ask you for information from your red, white, and blue Medicare card. Once you provide that information, it should tell you what plan you are enrolled in and whether or not you are receiving "extra help." If no plan is listed, make sure the information you recorded was correct. If the information is correct and there is still no plan listed, you may not be in any plan and will have to enroll.

2. I did not receive a member card from my plan- what do I do?

If you did not receive a card from your plan, you can use the confirmation letter that you may have received to get your medications. If you did not receive a confirmation letter, you should call the plan to get a member id number in order to obtain your prescriptions. If you have any problems getting your Medications filled, you can get an emergency 5-day supply provided by the state Medical Assistance program. Your pharmacy should now know how to bill the state for this.

3. How can I find out if this plan will cover my medications?

To find out if your medications are covered, you should call the plan, call 1-800-MEDICARE or log onto www.medicare.gov and follow the link for the formulary finder. Until March 31, all plans should be covering the medications you were taking under Medicaid. See question 7 for more on this.

4. How do I change plans?

Dual eligibles can change plans at any time, to be effective the first day of the next month. You can disenroll from your current plan and enroll in a different plan by calling 1-800-MEDICARE and asking to disenroll from the plan you are in and to enroll into a new plan or by calling the plan that you want to enroll in and enrolling.

5. Medicare says that I am not in a plan- what do I do?

If Medicare says that you are not in any plan, then you will need to pick a plan and enroll in a plan to get your medications covered starting next month. In the meantime, you can get

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an emergency five-day supply of medications from your pharmacy that can be billed to Medical Assistance. Furthermore, your pharmacy can enroll you in Wellpoint, a national prescription drug plan, in order to obtain a temporary, two-week supply of medications. However, you should then call 1-800-MEDICARE or use the Medicare Plan finder on Medicare.gov to choose a plan that is best for you.

6. Why do I have a copay for my medications?

Under the law that created the Medicare prescription drug benefit, persons with Medicare and Medical Assistance have co-payments on covered medications which cannot exceed $1-$5. If you are dual eligible and you are being charged more than $5, then your PDP may not be aware that you have the low-income subsidy or "extra help." For now, the state Medical Assistance program has been covering the excess co-payments for dual eligibles until the Medicare system gets up to date. Your pharmacy should know how to process this.

7. My plan won't cover my medications.

Every plan, whether it is an HMO or a stand-alone prescription drug plan, is required to have a transition plan to help ease the effect of the sudden change in coverage for dual eligibles .Through March 31, 2006, the Medicare HMO's are required to cover any prescription you had covered under your Medical Assistance HMO, and they must pay for dual eligible consumers to see providers that are not in the HMO's network. (See pages 1-3 for more on the Medicare HMOs). The transition plans for the stand-alone prescription plans (also in effect through March 31) require the plans to pay for a one-time fill of a month's worth of a medication that is not on the plan's formulary or would normally require prior authorization (without requiring the consumer to get prior authorization or an exception). So, you should be able to get your medication temporarily while you decide whether to change plans (see questions 3 & 4) or to seek an exception to your plan's normal rules about what drugs it will cover.

8. Does Medical Assistance cover any medications?

Outside of the special steps Medical Assistance has taken to remedy the problems dual eligibles have had under the new benefit, Medical Assistance will cover some medications. Medical Assistance will cover benzodiazepines, barbiturates, and some other the counter medications.

9. Can I enroll in PACE?

There is some ongoing debate as to whether dual eligibles are eligible for PACE, in addition to their Medicare and Medical Assistance. According to some state officials, dual eligibles are not eligible for PACE at this time because they receive some prescription drug coverage from Medical Assistance (extremely limited—see question 8). We do not believe the law intends this result. However, we are working to expand PACE's coverage to in-

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Other Big Changes for Dual Eligibles

On January 1, dual eligibles who were in Medical Assistance managed care organizations, (Keystone Mercy Health Plan, Americhoice, Health Partners, Gateway, MedPlus, UPMC for You, and AmeriHealth Mercy) were moved out of these HMOs and back into Access/Fee-for-Service Medical Assistance for their physical health services. Here are some questions and answers about the impact of the Medical Assistance changes on dual eligibles:

How do I see my providers?

Use your red, white and blue Medicare card and your Access card when you see providers. You can see any Medicare provider and any provider can bill balances to the Access program, even if the provider does not participate in Access. You should not be billed for Medicare or Medical Assistance covered services. If you were enrolled into a Medicare HMO, see the article on pages 1-3 as you should be able to see any providers who take Medicare at least until March 31, at which time you will either have to return to Original Medicare or switch providers, if your provider does not participate with the Medicare HMO.

How do I get an Access card?

You should have received an Access card when you were first enrolled in Medical Assistance. If you have misplaced it, you can get a new Access card by contacting your caseworker at the local County Assistance Office. In the meantime, your caseworker can give you the number from your Access card that you can use at the pharmacy or when seeing providers.

How do I see my behavioral health providers?

If you were in a behavioral health MCO before January 1, you are still in that HMO so continue to use your Medicare card and your MCO coverage as usual. If you are in a Medicare HMO, be certain whether the HMO will allow you to continue with your behavioral health providers after the transition period (after March 31). If not and you want to stay with those providers, you likely want to return to original Medicare by April 1, 2006. Your behavioral health medications will be covered by your Medicare prescription drug plan, except for benzodiazepines, barbiturates and some Over-the-Counter drugs—which Medical Assistance will cover for you.

How do I get to my medical appointments?

If you are dual eligible, you are still able to use Medical Assistance Transportation to get to your medical appointments. Contact your caseworker to find out how to sign up for MATP in your area.

How do I get services that are not covered by Medicare, like dental services?

You will use your Access card only for medical services not covered by Medicare. This means you will need to see a provider who will accept Medical Assistance. We are working with the state to get an accurate list of providers who will accept Access.

If you are having trouble accessing your health care, please contact the Pennsylvania Health Law Project helpline at 1-800-274-3258.

OMHSAS Announces Expansion of HealthChoices (HC) Behavioral Health Managed Care

In January, OMHSAS announced its intent to expand behavioral health managed care to the remaining 42 counties in PA. The initial plan was to divide the 42 counties in 2 zones with the state contracting with chosen vendors. That plan changed after the OMHSAS received feedback from the affected counties. The feedback indicated that counties should be offered the right of first opportunity to carry the risk by holding the contract directly with the chosen behavioral health plan. OMHSAS agreed and sent letters to all counties outlining their options.

Option 1 - Counties can decide to not assume the financial risk for behavioral health managed care. If counties opt to not assume the risk, OMHSAS will competitively select a licensed MCO from those qualified MCOs that respond to the HC RFP that will be issued by OMHSAS. OMHSAS will contract directly with the MCO and will be responsible to monitor performance of the contract. The county will participate as a partner with OMHSAS in contract oversight and program development. DPW will create one or two zones depending on the number of counties for which they will assume the risk.

Option 2 – Counties can accept the right of first opportunity. Under this option, the county can choose from 3 different models. The 3 models include:

1) The county manages the program directly with its own employees. With this model the county would respond to the OMHSAS RFP detailing how it will meet the required fiscal and program standards for the HC program.

2) The county may subcontract for program management services. In this case the county is required to select its subcontractor through a competitive process and the selected subcontractor must meet the applicable licensing requirements of the PA Departments of Insurance and Health. The county is also required to submit a response to the OMHSAS RFP detailing how the county and subcontractor will meet the required fiscal and program requirements for the HC program.

3) The county may choose to align with other non-HC counties in order to collaboratively manage the program. Under this arrangement the multi-county entity would be required to sign a single contract. These multiple county groups can choose to manage the contract on their own or to select a subcontractor through a competitive process.

Counties have until February 22, 2006 to communicate their option to OMHSAS. DPW-OMHSAS will issue the RFP in July 2006. Proposals will be due back to DPW by September 2006. Implementation for behavioral health managed care is intended for July 1, 2007.

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clude Medical Assistance consumers and we encourage you to apply for PACE.

I am in a Medicare HMO- how did I get into one and what can I do?

Please see the article starting on page 1 for a discussion about passive enrollment.

Are there any medications still covered by Medical Assistance?

Medical Assistance will still cover benzodiazepines, barbiturates and some Over-the-Counter medications. This means you will have to present your Access card at the pharmacy to get coverage for these medications.

If you have any problems with your Medicare Prescription Drug benefits, please contact the Pennsylvania Health Law Project helpline at 1-800-274-3258. Also, stay tuned to our web-site www.phlp.org for regular updates on the Medicare Prescription Drug benefit.

New Federal Poverty Levels Announced— Raises Income Eligibility Limits for MANY Program

The new federal poverty income guidelines are out! This means the income limits have increased for many state and federal programs. The increases will also affect eligibility for the Medicare Prescription Drug Low-Income subsidy or "Extra help." Below are the new guidelines for several programs. Remember, not all income counts. If you think you may be eligible for any of the programs, you can apply through your local county assistance office or on-line at www.compass.state.pa.us.

Program	**Monthly income 1 person**	**Monthly income 2 people**
Healthy Horizons	$817	$1,100
SLMB (Medicare Savings Program)	$980	$1,320
QI-1 (Medicare Savings Program)	$1,103	$1,485
MAWD	$2,042	$2,750
HCBS waiver	$1,809	$2,712
Full Low Income Subsidy for Medicare Prescription Drug benefit	$1,103	$1,485
Partial Low Income Subsidy for Medicare Prescription Drug benefit	$1,226	$1,650

Governor's Budget Would Expand Long-Term Care Services and PACE

The 2006-07 budget proposed by Governor Rendell on February 8 would increase long term care services, raise payments to nursing homes, and expand the state's pharmaceutical coverage for the elderly program (PACE).

The Governor would add 2,800 slots to the aging waiver for persons over age 60 to be served in the community rather than in nursing homes. This is a 14% increase. He would raise Medicaid payments to nursing homes by 4%. Finally, he intends to add an additional 120,000 persons to the PACE program, a 40% increase. He would use PACE to "wrap around" the Medicare Part D program, allowing those who qualify for PACE to avoid the Part D premiums, deductible and the donut hole. The state also plans to provide coverage for drugs not covered by a person's part D plan, either because the drug is off-formulary, or because of prior authorization barriers. This change would enable the state to gain savings from Part D, by eliminating any financial disincentive for seniors enrolling in Part D. Some of those savings are being used to fund the PACE expansion.

The budget process now moves to the Pennsylvania General Assembly where the legislature must pass a budget bill, hopefully by June 30, 2006, the end of the current fiscal year.

NEW ADDITION TO OUR TEAM:

The Pennsylvania Health Law Project welcomes the addition of Karly Grossman, an Independence Foundation Public Interest Fellow. Karly has been working with PHLP for 2 years as a legal intern. She is funded by the Independence Foundation to work on Medicare Part D issues. She is available for Medicare trainings in the 5 county Philadelphia area and for direct representation on Medicare Part D exceptions, coverage determinations, and appeals. Please help us welcome Karly to our team. Karly can be reached at kgrossman@phlp.org.

Are you receiving the Senior Health News by mail? Would you like to switch to e-mail? If so, please contact Jennifer Nix, at jnix@phlp.org to change how you get the Senior Health News.

State Creates Long-Term Living Council

The state has appointed Michael Nardone to lead the Long-Term Care Living Council, which was established in November, 2005. Its purpose is to address the challenges created by the increasing number of Older Pennsylvanians who will need long-term care services. The Council includes the Secretaries of Aging, Public Welfare, Budget, and Policy; the Deputy Chief of Staff, and the Director of the Office of Health Care Reform. The Council's agenda is to: 1) help those who want to leave nursing homes and return to their home or the community 2) ensure an adequate supply of nursing home beds, while creating opportunities for facilities to provide other long-term care services, 3) remove barriers to community-based waivers, 4) ensure consistency in the application of eligibility criteria, and 5) maximize available quality waiver services. The state has begun centralizing the waiver review process

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