Senior Health News

A publication of the Pennsylvania Health Law Project
1-800-274-3258/ 1-866-236-6310 TTY

Volume 8, Issue 3

June 2006

Personal Care Home Regulations Take Effect: Lawsuit against the Regulations Dismissed

As we previously reported, the new personal care home regulations that were due to take effect October 24, 2005 were the subject of a lawsuit filed by personal care home owners. A preliminary injunction had been granted in October 2005, holding up the implementation of 13 of the new Personal Care Home regulations. On May 24, 2006, the suit was dismissed. As of June 5, 2006, all of the new regulations are in place (although some were scheduled for delayed implementation and, thus, have not yet taken effect).

After five years of discussion and debate, the final form of the new regulations were promulgated in February 2005 and were supposed to take effect in October 2005. However, shortly after the regulations were implemented, a group of personal care home owners sued the Department of Public Welfare in Commonwealth Court, claiming that DPW went too far when it created the new regulations. An October court order prevented the Department from implementing 13 of the new regulations until a final decision on the suit could be made. The regulations that were not implemented included some very important provisions, including the rules about the degrees or training that personal care home administrators must have, as well as the section of the regulations that defined personal care services. The Pennsylvania Health Law Project jointly with Community Legal Services and the Disabilities Law Project filed an amicus brief on behalf of clients and client groups supporting the need for and validity of the new personal care home regulations.

The new personal care home regulations are available as a link off of the Personal Care Homes drop-down page on the www.phlp.org website. A new manual designed for select counties in the Northeast part of Pennsylvania which describing the rights of all of Pennsylvania's personal care home residents is also available on that page.

The new personal care home regulations provide better assurances that residents will re-

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Joining Medicare Part D or Wanting to Change Plans: What can be done after May 15th?

Enrollment Deadline

The 2006 deadline for enrollment into Medicare Part D was 5/15/06 and has passed. Most individuals who did not join a Part D plan by May 15th will have to wait until the Open Enrollment Period (11/15/06 through 12/31/06) to sign up with a Part D plan for coverage starting January 1, 2007. If these individuals do not have prescription drug coverage that is at least as good as the Medicare drug coverage, they will have to pay a penalty when they join a plan.

There are some exceptions that allow consumers to join Part D after the May 15th deadline and before the start of the Annual Open Enrollment Period. These exceptions include:

1. If a consumer qualifies for a Special Election Period (SEP) (for example, someone becomes a dual eligible- has both Medicare and Medical Assistance, someone enters or leaves a nursing home, or someone qualifies for the low-income subsidy—see more below).
2. If someone is in their Initial Enrollment Period for Medicare (for example, a consumer who turns 65 on August 15th has until November 30, 2006 to sign up for Medicare Part D without a penalty).

Special Enrollment for Individuals who Qualify for the LIS after 5/15/06

Low-income individuals who first qualify for the low-income subsidy after 5/15/06 will have a one-time opportunity to join a Part D plan if they are not enrolled in a plan already. If these individuals do not join a plan on their own, Medicare will enroll them into a plan. If Medicare enrolls these individuals into a plan, they can make one change before the end of the year. These consumers will not be charged a late enrollment penalty.

Changing Plans

Most consumers are now locked-in to their Part D plan until the end of December 2006 unless they qualify for a Special Election Period (SEP). However, all dual eligibles qualify for an ongoing SEP and can change plans at any time. There is no limit on how many times a dual eligible person can change plans. Others who qualify for a SEP include individuals who move out of their plan's service area or individuals who go into or come out of a nursing home.

Consumers can change plans by:

- contacting Medicare at 1-800-MEDICARE (voice) or 1-877-486-2048 (TTY)
- enrolling directly with the new plan
- enrolling online at www.medicare.gov

  Enrollment into the new plan will disenroll the consumer from their current plan.

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Coverage through their new plan should start the first of the month after they join the new plan. For example, if someone changes their plan June 20th, then their new coverage should start July 1, 2006.

Please contact the PHLP Helpline for further information at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY). For more information about Part D issues, visit www.phlp.org.

State still helping Full Dual Eligibles who have Problems with Part D Enrollment and Excessive Co-Pays

Problems with Enrollment into a Part D Plan:

Many dual eligibles are still experiencing significant problems with not being enrolled into the right Part D plan or into any plan at all, leading to problems accessing medications at the pharmacy. This is the subject of a nationwide class action lawsuit, Situ v. Leavitt. New dual eligibles who have become eligible for Medicare since January 1, 2006 are among those having a hard time because they often lose their Medicaid drug coverage before their Part D coverage begins.

When a full dual eligible (someone who has Medicare and full Medicaid benefits through an ACCESS card) does not have coverage through a Part D plan and needs medications, there are two back-up processes that pharmacies can use in order for that individual to get their prescriptions:

1) **POS/Facilitated Enrollment (Anthem/Wellpoint)—**When a full dual eligible goes to the pharmacy and does not have a Part D plan, the pharmacy can bill Anthem/Wellpoint and the consumer can get a 14 day supply of medication. This process is still in place for dual eligibles and can be used multiple times until the individual's coverage starts through a Part D plan.
2) **Emergency Supply through MA**—When all attempts have failed to get medication covered by a Part D plan and/or the Anthem/Wellpoint process, the consumer may be able to get a temporary emergency supply of medication through Medical Assistance. Starting around June 19th, the pharmacy will need to call the Department of Public Welfare in order to get authorization for this temporary supply.

Problems with excessive co-pays:

All dual eligibles automatically qualify for the full low-income subsidy. This means that they have no annual deductible and $1-$5 co-pays for medications covered by their Part D plan. Many dual eligibles have been charged high co-pays at the pharmacy because their plan does not have information about their subsidy eligibility. This problem is also the subject of the Situ v. Leavitt suit.

In Pennsylvania, when full dual eligible consumers are being charged more than a $5 co-pay for a drug covered by their Part D plan, the pharmacy can bill MA for any co-pay amount over $5. Instructions for these back-up processes can be found on our website at www.phlp.org. Please call the HELPLINE at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY) if you have any questions about these back-up processes.

Medicare Special Needs Plans Transition Period Ending June 30, 2006

In the April 2006 edition of the Senior Health News, we reported that the transition period for dual eligibles who were passively enrolled into Medicare Special Needs Plans (SNPs) had been extended to June 30, 2006 as part of the settlement agreement in Erb V. McClellan (a lawsuit that PHLP, Community Legal Services, and the Center for Medicare Advocacy filed on behalf of dual eligibles who had been passively enrolled into Medicare HMOs). During this transition period, the Medicare SNPs were required to pay for services provided by all out-of-network providers and all non-formulary drugs that consumers had been taking prior to January 1, 2006.

Starting July 1, 2006, dual eligible consumers who were passively enrolled into these plans will be locked-in to the plan's provider networks, formulary, and rules for accessing care. The Medicare Special Needs Plans are supposed to be calling all members who have been seeing out-of-network providers to inform them that they should change plans by the end of June if they want to continue seeing that provider.

Before the end of this month, consumers who had been enrolled in these Medicare Special Needs Plans should:

- make sure all their providers are in their plan's network;
- make sure all of their drugs are covered by the plan's formulary; and
- find out their plan's rules for accessing care.

Dual eligible consumers can change Part D plans at any time. Consumers who do not want to be locked-in to their plans network, formulary, or rules for accessing care should change plans before the end of June. If they do so, their new plan will be effective July 1, 2006.

Just as a reminder, consumers can join a stand-alone Prescription Drug Plan that will work with their original Medicare and ACCESS card, or they can choose to join another Medicare HMO with drug coverage.

If consumers have any questions about the end of the transition period or have any problems disenrolling from their Medicare Special Needs Plan, they should contact the PHLP Helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

Attached is a one-page hand-out on what happens after June 30th. Please help us disseminate this fact-sheet.

What Happens After June 30th for Passively Enrolled Dual Eligibles?

For the over 100,000 dual eligibles who were passively enrolled into a Medicare HMO as of January 1, 2006, June 30th means the end of their "transition" or "grace" period. How will this impact their ability to access healthcare and prescription medications?

- **Starting July 1, 2006, Medicare HMO members will only be able to see providers that participate in their Medicare HMO's network.** During the Transition Period (January 1, 2006 to June 30, 2006), passively enrolled individuals were entitled to see any Medicare providers they wished, regardless of whether the provider participated in the Medicare HMO plan network. Starting July 1, 2006, those who remain enrolled in a Medicare HMO will only be able to see the providers who participate in their plan's network.

- **Starting July 1, 2006, Medicare HMO members will have to obtain referrals to see specialists and prior authorizations for select services, as required by their Medicare HMO.** During the Transition Period, passively enrolled individuals were entitled to see specialists and obtain services without having to obtain referrals or prior authorizations from their primary care provider (PCP). Starting July 1, 2006, those who remain enrolled in a Medicare HMO will only be able to see specialists who participate in their Medicare HMO plan and obtain services available under their Medicare HMO plan when referred by their PCP and/or, where necessary, prior authorized by their plan.

- **Starting July 1, 2006, Medicare HMO members will only be able to obtain the prescription medications contained on their Medicare HMO's formulary (list of covered drugs).** During the Transition Period, passively enrolled individuals were entitled to obtain any prescription medications they were on through Medicaid prior to January 1, 2006 even if the medication is not normally covered by the Medicare HMO. Starting July 1, 2006, those who remain in their Medicare HMO plan will only be able to obtain the medications on their plan's formulary and will be subject to any restrictions on access to medications imposed by their plan.

- Payment for medications not on the Medicare HMOs formulary may be requested from the Medicare HMO by following the HMO's exceptions process. Medications on the Medicare HMOs formulary but denied as not being needed by you individually may be appealed through the Medicare HMO's appeals process. For more information about either of these processes, please see our website at www.phlp.org or call us at 1-800-274-3258.

- **After July 1, 2006, Medicare HMO members can still change plans and leave their HMO.** Persons with Medicare and any Medicaid can change plans at any time effective the first day of the next month. Thus, if you did not change before June 30 and realize at any later time that the Medicare HMO does not work for you, you may elect another plan. 1-800-Medicare can help you pick a plan that covers the medications you take. A list of the 15 stand-alone drug plans that are available to dual eligibles with no premium is available at our website www.phlp.org or by calling us at 1-800-274-3258/1-866-236-6310 TTY.

Behavioral Health Managed Care Begins July 1, 2006 for the Northeast Counties of Lackawanna, Susquehanna, Luzerne and Wyoming.

Beginning July 1, 2006, people on Medical Assistance in Lackawanna, Susquehanna, Luzerne and Wyoming counties will receive behavioral health services through a managed care plan. Each of the four counties has contracted with the same managed care plan for services. That plan is Community Care Behavioral Health (CCBH). This will mean a new way of getting mental health and drug & alcohol services for the majority of people on Medical Assistance in these four counties.

How Will I Access Services Differently than I do Now?
Now, if you have Medical Assistance, you are in what is called the Fee-For-Service system, which means you must receive mental health and drug & alcohol services from any Medical Assistance provider. With CCBH, you must receive services from providers that are a part of the CCBH network unless CCBH gives you approval to see an out-of-network provider.

How Will I Know What Providers are in the Network of CCBH?
If you are currently receiving mental health or drug & alcohol services you can ask your providers if they contracted with CCBH. You can also call CCBH at 1-866-688-4696 to find out what providers are in their network.

What if the Provider I am Now Getting Services from is not in the CCBH Network?
That should not happen but if it does you will be given time to transition to a new provider in the network of CCBH.

Will the Same Type of Mental Health and Drug & Alcohol Services be Available thru CCBH?
Yes, CCBH will offer all the same services that are available through Medical Assistance plus additional services. The additional mental health services include: Intensive Case Management (ICM) and Resource Coordination (and other services for children). The additional drug & alcohol services include: Intensive Outpatient, Partial Hospitalization, Halfway House, Non-hospital Detoxification and Non-hospital Rehabilitation. There may be other services as well. You will receive a Member Handbook from CCBH that will list all the available services.

Will Anything Change Regarding How I Access Mental Health Medications?
No. You will still access prescription medications for mental illness the same way you do now.

Will Any Services Require Prior Authorization?
Yes, most services will require authorization by CCBH. Mental health services each have medical necessity criteria that must be met for CCBH to approve the service. Drug & alcohol service providers use an assessment tool called the PA Client Placement Criteria (PCPC) to determine what level of D&A treatment you need. CCBH must first approve that level of treatment before you can begin receiving services.

What Can I do if the Service my Provider Thinks I Need is Not Authorized by CCBH?
You can request an appeal. You can still request a fair hearing appeal as you can do now in

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Medical Assistance Fee-For-Service. You will also be able to appeal by requesting a grievance through CCBH. Any denial of service from CCBH will include information about how to file a grievance and/or fair hearing.

Will I Automatically be Enrolled in CCBH?
Yes. You will be automatically enrolled unless you are a member of a group that is exempt from managed care. The exempt groups are: those in the HIPP Program, in a nursing home or in certain waivers such as Aging, Michael Dallas or the AIDS waiver.

Problems unfold for Dual Eligibles trying to get Mental Health Services

New policies that require dual eligibles to see Medicare participating Mental Health providers would pose significant restrictions on how dual eligibles access their health care. Until now, dual eligibles have been able to obtain mental health services from any Medicaid provider, regardless of whether the provider also takes Medicare. A new policy would require dual eligibles to see a provider that takes Medicare. This policy causes problems. Many behavioral health providers take only Medical Assistance and do not, at present, and cannot, with any due speed, become Medicare providers. If this policy takes full effect, the result will be that consumers will be unable to see providers they have come to know and trust.

Dual Eligible consumers having problems seeing their MH provider should contact the Pennsylvania Health Law Project helpline at 1-800-274-3258 to let us know.

Attention advocates in Southwestern and Southeastern PA helping consumers with Medicare Part D issues

PHLP staff are available in Southwestern and Southeastern PA to conduct trainings on Part D to help you help your 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. If you want to learn how to help get your clients' needs met through Medicare Part D, please 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 hearing and/or visual impairments and we would be glad to accommodate your needs.

In addition, PHLP is launching a Part D listserve for advocates working with dual eligibles 60 and over in the five county Philadelphia region. This listserve will update local advocates about changes for dual eligibles, particularly regarding Part D. To join, please send an email to Jennifer Nix at jnix@phlp.org with your organization, contact person number and email address, location and general description of your client base.

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ceive the care and services they need than did the old personal care home regulations. Among other things, the new regulations require that an individualized assessment and support plan be completed at least annually articulating what the resident needs and how those needs will specifically be met. The new regulations establish permissible grounds for transfer and discharge (before residents could be discharged for any reason or none at all). The new regulations improve the training and qualifications of administrators and staff and require that both demonstrate competency in the training topics prior to working independently with residents in those areas. The new regulations require greater reporting by personal care homes of incidents and deaths to the Commonwealth so that improved monitoring can be done.

The Commonwealth Court found in favor of the Department of Public Welfare and dismissed the suit. The state can now fully implement the new regulations, although the providers may appeal. 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.

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

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