SENIOR HEALTH NEWS

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Medicare's Coverage of Durable Medical Equipment and Supplies Changing July 1st

Starting July 1st, Medicare is changing how many beneficiaries in Western Pennsylvania obtain their Medicare-covered durable medical equipment (DME) and supplies. This new program, called the Competitive Bidding Program, is being initially rolled out in 10 areas throughout the country. The Pittsburgh area (which includes Allegheny and surrounding counties) is one of the 10 areas initiating this program.

Who will be affected ?

The Competitive Bidding Program will affect anyone:

- Who is in Original Medicare* (uses their red, white and blue Medicare card to obtain health care); and
- Who lives in a zip code in the Pittsburgh Competitive Bidding Area or who travels to a zip code in the Pittsburgh Competitive Bidding Area; and
- Who needs any of the DME or supplies covered by the Program (see the next page for a list of the DME and supplies).

** Note: This new program does not affect beneficiaries enrolled in a Medicare Advantage (managed care) Plan.*

How do I know if I live in the Pittsburgh CBA?

The Pittsburgh Competitive Bidding Area includes:

- All of Allegheny County;
- Most of Washington, Westmoreland, Fayette, Butler, Armstrong and Beaver Counties; and
- Small sections of Clarion, Greene, Indiana, Jefferson, Lawrence, Somerset and Venango Counties.

A complete list of zip codes included in the Pittsburgh CBA can be found at www.dmecompetitivebid.com or individuals can call Medicare at 1-800-633-4227 (voice) or 1-877-486-2048 (TTY) to see if their zip code is on the list.

How does the new program work?

Up until now, Medicare beneficiaries with a prescription for DME or other supplies could go to any Medicare-approved supplier to fill their prescription. Under the Competitive Bidding Program, however, beneficiaries will only be able to get certain DME and supplies (see next page) through a very limited network of providers who received a contract from Medicare.

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Medical suppliers had to submit bids to Medicare for various items covered by the program. Medicare awarded contracts to suppliers that offered the best price for DME and/or supplies and that met other Medicare standards. These contract suppliers cannot charge more than the single payment amount set by Medicare based on the bids received for a particular item and they can only charge the beneficiary a 20% co-pay (and any portion of the Part B annual deductible that has not yet been paid). Individuals can find a list of contract providers by going to www.medicare.gov/suppliers or by calling Medicare at 1-800-633-4227 (voice) or 1-877-486-2048 (TTY).

What types of DME and supplies are included in the Competitive Bidding Program?
The following types of Medicare-covered medical equipment and supplies are included in the new program:

- Oxygen supplies and equipment
- Standard power wheelchairs, scooters, and related accessories
- Complex rehabilitative power wheelchairs and related accessories
- Mail-order diabetic supplies
- Enteral nutrients, equipment and supplies (such as a G-tube or J-tube)
- Continuous Positive Airway Pressure (CPAP) devices, Respiratory Assist Devices (RADs), and related supplies and accessories
- Hospital beds and related accessories
- Negative pressure wound therapy pumps and related supplies and accessories
- Walkers and related accessories

Will consumers be required to change their providers under this program?
It depends. If the consumer's current provider has not been awarded a contract from Medicare, they can only stay with that provider and continue to get Medicare-covered equipment and supplies if:

- The consumer is currently renting certain DME from the supplier such as oxygen equipment or a hospital bed; and
- The provider becomes a "grandfathered" supplier (**Note**: suppliers were required to provide written notice to their consumers before July 1st telling them whether or not they will be a grandfathered supplier).

Once the current rental agreement ends, an individual must switch to a contracted supplier to continue getting the Medicare-covered item.

If a current supplier decides to become a "grandfathered" supplier, the consumer is not required to stay with that supplier. The consumer can change to a contracted supplier after July 1st, and the contracted supplier must honor the rental agreement.

After July 1st, Medicare consumers must use a contracted supplier or a grandfathered supplier to get Medicare coverage of the equipment and supplies listed above. If a consumer uses a supplier who does not have a contract with Medicare or who is not grandfathered, she will be asked to sign an Advance Beneficiary Notice (ABN) indicating that Medicare will not pay for the item or service received. **If a consumer signs this notice, she will be responsible for the costs of the item or service she receives.**

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What else is important to know about the Competitive Bidding Program ?

- This new program only impacts certain durable medical equipment and supplies that are listed above; it does not affect the doctors, hospitals, or other healthcare providers an individual can see.
- Medicare-contracted suppliers may not charge consumers more than the 20% coinsurance (and any applicable Part B deductible).
- If someone has insurance primary to Medicare (for example, if someone is still working and receiving coverage through their employer, this coverage may be primary to Medicare) and that primary insurance requires that they use a non-contracted supplier, Medicare may still pay its share for equipment and supplies as long as the supplier meets Medicare standards.
- If a person lives in the Pittsburgh Competitive Bidding Area but travels to a non-Competitive Bidding Area and needs any of the items listed above, she can use any Medicare supplier in the area.
- If someone owns equipment (such as a scooter) which was purchased before July 1, 2008, they can use **any** Medicare-approved supplier for repairs or replacement parts.

Medicare sent notice about the changes to beneficiaries living in the Pittsburgh CBA via mail starting on June 20th. In addition, a statement about the Competitive Bidding Program will be included in the Medicare Summary Notices beneficiaries receive for months in which they have received healthcare services billed to Medicare.

Consumers and advocates have expressed concerns over the Competitive Bidding Program and how it is being implemented. These include:

- Concerns that Medicare did not start to notify individual consumers until June 20th about a program that would begin on July 1st;
- Concerns that many consumers will not understand the notice and how the new program will affect them;
- Concerns that very little education and outreach to beneficiaries, family members, providers and other advocates is occurring that would minimize the chaos this new project could cause.

If you have any questions or want more information about the Competitive Bidding Program, please contact our HELPLINE at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

Please Note: Congress did not pass Medicare legislation that would have delayed the implementation of this program prior to leaving for the July 4th recess, so implementation of this program is moving forward as scheduled. Stay tuned to future editions of this newsletter and check our website (www.phlp.org) for updates about any possible changes or delays to the Medicare Competitive Bidding Program in the weeks and months ahead.

Do you currently get the Senior Health Law News through the mail? Please consider switching to e-mail!!

Contact staff@phlp.org to change the way you get the Senior Health News!

Assisted Living Update

The PA Assisted Living Consumer Alliance (PALCA) website is up and running at www.paassistedlivingconsumeralliance.org! As announced in our previous newsletter, PALCA is a collaboration of consumers, family members, and local and statewide organizations working to make sure the consumer voice is heard in the development of the assisted living regulations. The website includes more information about the Alliance and about assisted living in PA. In addition, it includes links to relevant news articles and information about the participating organizations.

PALCA is encouraging individuals to share their assisted living stories and experiences-good and bad-through the website. The stories are being gathered to help ensure that adequate standards and protections are included in the assisted living regulations. Individuals who submit stories will be asked for their permission regarding how their stories can be used. These stories will not be used in any way without the individuals' permission.

PALCA was featured in the Philadelphia Daily News this month, responding to the situation with the Lavin Homes and the Lavin settlement with the US Attorney's office. Rosalind Lavin, who operated four personal-care homes in Southeastern PA, reached a civil settlement in a fraud lawsuit. The lawsuit alleged that she used resident's Social Security benefits for her own use rather than to pay for providing care to the residents. The lawsuit also described the deplorable conditions of the homes in which the residents lived. Lavin agreed to pay $700,000 as part of the settlement and she agreed never to operate a personal care home again. A news article on this issue and a follow-up editorial written by Alissa Halperin, senior attorney at PHLP who is leading PALCA's efforts, highlights the importance of developing stringent assisted living regulations. The article also encourages people to comment on the soon to be released draft regulations to guarantee that Pennsylvanians who will live in assisted living facilities receive safe and appropriate care. You can view the news article on the PALCA website.

Regulations Update

The proposed assisted living regulations are expected to be published in the PA Bulletin in early July. Please check the PALCA website frequently for updates. Once the draft regulations are released, the website will include a link to the proposed regulations. Contact Alissa Halperin at ahalperin@phlp.org to be added to the e-mail list of those who will receive notice of the proposed regulations once they become available.

PHLP's Philadelphia Office Moving at the End of July

Effective July 26, 2008, PHLP's Philadelphia Office will have the following new address:

Pennsylvania Health Law Project
The Corn Exchange
123 Chestnut St. Suite 400
Philadelphia, PA 19106

All phone numbers and emails will remain the same.

UNITED WAY SUPPORTS PHLP

PENNSYLVANIA HEALTH LAW PROJECT, after an intensive competition involving almost 550 agencies, has been awarded $14,226 by United Way of Southeastern Pennsylvania. This is the first time that PHLP has been a recipient of United Way General Operating Support.

The grant, expected to be renewed for two additional years pending the results of future United Way campaigns, is to help with the general operating expenses of the organization rather than directed to a specific program. The agency said that while United Way placed no restrictions on the use of the funds, it provided the funds because of PHLP's success in developing and enlisting public support for public policy changes and increased public resources to assure that seniors have access to supportive services they need for healthy aging at home.

PHLP has a long history of public education through its website, www.phlp.org, its bi-monthly publication "Senior Health News," and public education seminars for consumers, advocates, social service agencies and health care providers. PHLP actively participates with, and on behalf of, consumers on the Long Term Care Delivery System Subcommittee of the Medical Assistance Advisory Committee, the Pennsylvania Intragovernmental Long Term Care Council and a host of other entities which seek to assure that seniors can age at home.

United Way's *Investing in Results* process was its first competitive funding process in many years. Previously, United Way supported a selected group of high-quality agencies that had been chosen over the course of its 87 year history. But several years ago, United Way announced that it was revitalizing its funding model and beginning with its most recent fundraising campaign, it would look for and fund organizations that have a strong track record aligned with United Way's three areas of focus – supporting children to enter school ready to learn and stay on track to graduation, supporting families in achieving financial self-reliance, and helping seniors remain healthy and safe in their own homes.

United Way considered over 2,100 proposals from 546 agencies in the *Investing in Results* process, ultimately selecting 137 agencies, an increase of sixty agencies over its former list of 77. Ninety-three of the agencies selected had not previously received United Way funding.

Correction to Article in April/May 2008 SHN

The previous SHN (April/May 2008) included an article about the impact of the economic stimulus payments on eligibility for public health programs. In that newsletter article, we erroneously reported that SSI benefits would count as income in terms of qualifying someone for the economic stimulus payments if a tax return was filed by October 15, 2008. That information was incorrect. **Income from SSI benefits does not qualify someone for these payments**. However, individuals who receive Social Security income (such as retirement, survivor, or disability benefits) may qualify for the economic stimulus payments if they received at least $3,000 from these sources in 2007 and if they file a tax return by October 15, 2008.

The complete revised article can be found in the April/May 2008 SHN available on our website at www.phlp.org. We apologize for the error and any confusion this may have caused.

NFCE Issue Update

PHLP recently learned that the Office of Long-Term Living (OLTL) has been conducting training with Area Agency on Aging (AAA) staff across the state on the new Nursing Facility Clinically Eligible (NFCE) standard. The NFCE standard has not been released to the public as of yet despite promises from OLTL staff that the standard would be released to the public *before* trainings began. The NFCE clarification included in the training packet is to go into effect on July 1, 2008 for all assessments and reassessments that AAA staff perform to determine whether someone clinically qualifies for MA coverage of nursing home care or for the Aging, Attendant Care, Independence, or COMMCARE Waiver Programs.

Members of several advisory committees, including the Consumer Subcommittee of the Medical Assistance Advisory Committee, submitted comments on the draft clarification of the NFCE definition issued in recent months and discussed in the previous SHN. Comments submitted by the Consumer Subcommittee focused on the need to change the definition of NFCE to: more accurately reflect the federal definition (intermediate or skilled level of care need rather than just skilled care); not require services to be provided under the supervision of a doctor; include examples of cases where someone had an intermediate level of care need and could be determined NFCE; clarify that individuals should not be terminated from the waiver if they require an intermediate level of care and their condition has not improved. Finally, comments submitted emphasized the need for the process to be public.

The information included in the training packet appears to address some of the concerns raised by the Consumer Subcommittee and other advisory groups. According to information in the training packet, the clarified definition of NFCE states:

1. The individual has an illness, injury, disability or medical condition diagnosed by a physician; **and**
2. As a result of that diagnosed illness, injury, disability or medical condition, the individual requires care and services above the level of room and board; **and**
3. A physician certifies that the individual is NFCE; **and**
4. The care and services are **either:**
   a) skilled nursing or rehabilitation services as specified by the Medicare Program in 42 CFR §§ 409.31(a), 409.31(b)(1) and (3), and 409.32 through 409.35; **or**
   b) health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program of health care and management and were previously available only through institutional facilities.

The training materials include examples about consumers requiring an intermediate level of care need. However, whether those consumers would meet the definition of NFCE is something that is discussed at the training sessions and answers were not provided in the materials about how OLTL is advising the AAAs to interpret the various scenarios.

The training materials indicate that a bulletin with the NFCE clarification will be finalized and gave a target date of 6/16/08 for this to occur. As of the printing of this newsletter, a final bulletin with the NFCE clarification has not been issued.

PHLP, along with various advisory groups, will continue to monitor this issue to determine whether the new NFCE definition will result in fewer wrongful denials and/or terminations from Waiver Programs or nursing home care.

Settlement Reached in Nationwide Class Action Lawsuit of Part D Problems for Dual Eligibles

A settlement agreement has been reached in a nationwide class action lawsuit between dual eligibles (people that have both Medicare and Medical Assistance) and the Secretary of the U.S. Department of Health and Human Services. The lawsuit, Situ v. Leavitt, was filed in federal court in San Francisco, CA over the numerous problems that dual eligibles faced with the implementation of the Medicare Prescription Drug Benefit-Part D. In particular, the lawsuit cited the systemic delays in regard to auto-enrollment into a Part D plan and the deeming of these individuals as eligible for the full low-income subsidy which created many problems for dual eligibles when they tried to get their medications.

The lawsuit was filed in April 2006, and the case was certified as a nationwide class action in January 2007. Settlement negotiations have been ongoing since the Spring of 2007. The plaintiff class was represented by the Center for Medicare Advocacy, the National Senior Citizens Law Center, and a private law firm from California (Wilson, Sonsini, Goodrich, & Rosati). According to the settlement agreement, states will be able to submit data files to the Centers for Medicare & Medicaid Services (CMS) more frequently than once a month to speed up the auto-enrollment process. Under the current system, states send data to CMS once a month resulting in a delay of at least a month to 6 weeks (and sometimes longer) before an individual is identified by Medicare as a dual eligible, auto-enrolled into a Part D plan, and deemed eligible for the full low-income subsidy.

The settlement agreement also includes a process for the CMS Regional Offices and Part D plans to identify a dual eligible and update the plan's systems to reflect the correct LIS co-pay amount. Under the current system, beneficiaries who are identified in the plan's system with the incorrect LIS cost-sharing amounts have to submit paperwork (such as a Medicaid eligibility notices) to the plan in order for the plan to update their systems with the LIS co-pays. The new process puts the burden on the CMS Regional Offices rather than the beneficiary. The Regional Offices can contact states to confirm dual eligible status and LIS-eligibility and then notify the plans to update their systems with the correct LIS co-pay amounts.

Other aspects of the settlement include CMS' agreement to educate pharmacy organizations about dual eligible protections for those who have not yet been auto-enrolled into a Part D plan and are unable to get their medications. CMS also agreed to hold quarterly meetings with the attorneys for the plaintiff class to monitor implementation of the settlement and discuss issues facing dual eligibles.

According to the Center for Medicare Advocacy, it could still be several months before the settlement receives final approval and goes into effect. PHLP (as well as other organizations around the country who work with dual eligible individuals) provided information to the plaintiff attorneys about the various problems faced by the dual eligible consumers who contacted us for help. We hope this settlement brings about positive changes to improve the system for dual eligibles. The settlement agreement can be viewed at www.medicareadvocacy.org/SettlementAgreement.pdf.

A Change in Leadership at PHLP

We are sad to announce that Michael Campbell has resigned as Executive Director of the PA Health Law Project to accept a teaching position at Villanova Law School. Mike has been the Executive Director of PHLP since 2003. Under his exceptional leadership, our budget has grown and our staff expanded, allowing us to now handle over 350 calls per month through our Helpline. Mike has been a dedicated and tireless advocate for low income families, persons with disabilities, and the elderly at the federal, state and local levels. Some of the highlights of Mike's work including fighting for policies that would: increase consumer access to publicly-funded health insurance programs, regulate and monitor hospital uncompensated care (a/k/a "charity care") programs, and track and address racial discrimination in nursing home admission policies and practices.

We will miss Mike's humor and wisdom as well as his enthusiastic commitment to PHLP's mission. Although we are sorry to lose Mike, we are glad he is being given the opportunity to teach and to mentor the next generation of public interest lawyers. Mike will be leaving PHLP at the end of July. PHLP's Board of Directors has announced that until a new permanent Director is hired, Leonardo Cuello, a staff attorney in our Philadelphia office, is appointed as Interim Director.

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