SENIOR HEALTH NEWS

Call The Pennsylvania Health Law Project
Help-Line to Sign Up –1-800-274-3258 or 1-866-236-6310/TTY
Email staff@phlp.org

Volume 9, Issue 4

August 2007

Assisted Living Legislation Passed

In July, the Pennsylvania General Assembly passed an Assisted Living licensing law. Act 56 of 2007 charges the Department of Public Welfare with crafting regulations for licensure of Assisted Living Facilities. No facility can obtain licensure until the Department has final regulations in place. Additionally, no facility can call itself Assisted Living unless it has been licensed by the Department as such.

The details of how care and services will be delivered, how staff will be trained, and more remain to be articulated in the regulations, however, the standards are required, by the law, to meet or exceed those that apply to personal care homes at present. Many believe this provides a good foundation upon which to build the new standards. Others are concerned that the existing personal care home regulations have not sufficiently protected those low-acuity individuals residing in personal care homes and that any standards for higher-acuity populations, like the population anticipated for assisted living, must significantly exceed existing personal care home standards.

The law permits nursing facility clinically eligible individuals to reside in licensed Assisted Living Facilities and receive supplemental services therein permitting them to potentially "age in place". Some consumers will not be allowed to enter or remain in an ALF due to the law's list of excludable conditions. The law also permits facilities to obtain written waivers of liability (called informed consent agreements) for resident activity or behavior that counters the facilities recommendations for the resident.

It is expected that Home and Community Based Services Waiver dollars will soon be available to help fund care in an Assisted Living Facility, and the Department of Public Welfare has announced plans to submit a waiver application to the Centers for Medicare and Medicaid Services expressly to fund assisted living services provided in assisted living facilities.

The new assisted living law provides a long overdue framework for licensing assisted living facilities. Most of the details about how facilities will look, function, and serve consumers will evolve through the regulations process. The regulations process is expected to begin this fall, with proposed regulations likely to be published in the Pennsylvania Bulletin by the winter. A public comment period will then follow. The Pennsylvania Health Law Project will provide updates in the months ahead.

"Re-deeming" of Dual Eligibles for the Part D Low-Income Subsidy for 2008 Has Begun

Individuals who have Medicare and get any help from the Medical Assistance (MA) Program (including full/partial MA benefits and/or help paying their Part B premium) automatically qualify for the full low-income subsidy (LIS) to help with their Medicare Part D costs. Dual eligibles are identified to Medicare on a monthly data file sent to Medicare by the State. When Medicare receives information from the State data file, Medicare updates its records to "deem" the identified beneficiaries eligible for the full LIS for the remainder of the calendar year.

Every year, in August, Medicare begins the "re-deeming" process to identify beneficiaries who will be eligible for the LIS in the following year. Medicare uses the July file sent by the States to start this process. So, any Medicare beneficiary who has been deemed eligible for the LIS in 2007 and who appears on a monthly file between July and December 2007 will be "re-deemed" for the full LIS for all of 2008. Individuals who appear on the monthly file for the first time between July and December 2007 will be deemed eligible for the LIS for the remainder of 2007 and all of 2008.

Individuals who were deemed eligible for the LIS in 2007 but who do not appear on the July or August files sent by the State will receive notification from Medicare in late September or early October telling them they no longer automatically qualify for the full LIS in 2008. The notices will include an LIS application that can be completed to see if they qualify for any LIS in 2008. Individuals who receive these notices but who then go back on Medical Assistance at some point before the end of the year should appear on a monthly file and be deemed eligible again for the full LIS for 2008. However, individuals who get this notice from Medicare and who do not get any Medical Assistance benefits for the remainder of the year will lose their LIS on December 31, 2007 unless they apply for this help and are approved.

Remember, once a dual eligible individual is deemed eligible for the LIS, they get that help for the rest of the calendar year (even if they lose their Medical Assistance).

The Social Security Administration will begin doing redeterminations of individuals who are non-dual eligibles but who were approved for the LIS between May 2006 and April 2007. SSA will start sending out the redetermination letters in August. Individuals should be on the lookout for this information and read this information closely to determine whether they have to send information back to Social Security within certain timeframes in order to continue getting the LIS in 2008. Generally, individuals will only have to respond to Social Security if the income and asset information listed in the redetermination letter from SSA has changed.

If you have any questions about the LIS redeeming or redetermination processes, please contact the PA Health Law Project HELPLINE at 1-800-274-3258 or 1-866-236-6310 (TTY).

Are Medicare Advantage Special Needs Plans Doing Anything Special To Meet Their Enrollees' Special Needs?

Special Needs Plans are Medicare Advantage plans (usually HMOs) that are permitted to limit their enrollment to special needs populations. Special needs populations are 1) persons who are dually eligible for Medicare and Medicaid, 2) "institutionalized individuals", and 3) persons with chronic health conditions. Congress is focusing on SNPs over the next few months because the Medicare Modernization Act of 2003 only authorized SNPs for 5 years, and the authorization ends in 2008. The CHAMP Act would extend the authority for SNPs for an additional three years, however, it does not specifically address many of the issues being raised about the care, services, and benefits the SNPs are providing their enrollees.

Pennsylvania has a very high concentration of enrollees in SNPs due to the passive enrollment of over 110,000 of Pennsylvania's dual eligibles into dual eligible SNPs back in 2006. Since January 2006, Dual eligibles have called PHLP with various issues related to their efforts to access care within their SNPs. **With so many consumers in our state in SNPs, these issues are of great concern to PHLP.** Complaints and concerns have been raised with CMS about such things as: 1) SNPs for dual eligibles have providers who refuse to accept Medicaid 2) SNPs for dual eligibles have providers that balance bill Medicaid recipients for amounts unpaid by Medicare 3) SNPs for dual eligibles are not instructing providers about what Medicaid will cover for their patients 4) SNPs for dual eligibles are not informing their pharmacies of what Medicaid will cover or requiring them to bill the Medicaid program for covered drugs 5) SNPs for dual eligibles are not informing enrollees that Medicaid might cover a service that the SNP doesn't 6) SNPs for dual eligibles are simply denying services the SNP doesn't cover and not helping the enrollee to obtain the service (or even explaining how to pursue independently) Medicaid coverage of the item or 7) SNPs for dual eligibles that do include information about Medicaid coverage are providing information that inaccurately presents what Medicaid does cover.

In theory, SNPs are positioned to focus attention on the special needs of the consumers they serve. In reality, however, few requirements are in place to ensure that SNPs actually meet the special needs of their enrollees. There are no regulations that articulate how an HMO qualifies for "special needs plan" designation. There are no regulations expressly requiring SNPs to in fact meet their enrollees' needs, coordinate their care, and more. And, CMS's regional office states this as their response to the client concerns described above. This is a serious problem that PHLP is very interested in resolving.

Because SNP enrollees want SNPs to be required to actually, meaningfully meet their enrollees' special needs, our readers are invited to refer clients to our toll-free helpline (800)274-3258, share your stories with us at (800)274-3258 or (866)236-6310 TTY, or forward directly to us at staff@phlp.org summaries of similar type problems (redact names if need be) that you have seen in your dealings and experiences with SNPs and SNP enrollees. They do not have to be current problems that still need resolution (although please refer those to us so we can help you swiftly help the individuals). Please let any of our staff know if you need more information about Medicare Advantage Special Needs Plans serving the area.

Please feel free to copy and post or distribute this announcement.

SENIOR HEALTH NEWS

PHLP Pennsylvania Health Law Project

Medical Assistance Transportation Program (MATP) Basics Training

Learn how MATP works in Philadelphia and gain helpful tips in obtaining MATP services

Wed. October 10, 2007
10:00 -11:30 AM
Philadelphia

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Help-Line to Sign Up —1-800-274-3258 or 1-866-236-6310/TTY

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Email staff@phlp.org

Visit us online at www.phlp.org !!

Location

Philadelphia Bar Association
1101 Market Street—11th Floor
Philadelphia, PA

Note: Arrive early and Bring Photo ID to get through Building Security

Medicare Issues Updated Policy to Part D Plans To Correct Low-Income Subsidy Status Based on Best Available Evidence

The process by which dual eligible individuals are "deemed" eligible (automatically qualify) for the full low-income subsidy is described on page 2. Because the State only shares information with Medicare once a month, it usually takes a couple months for a new dual eligible to be identified by Medicare as a dual with the LIS. Because of these delays and other problems with the data transferring, Medicare developed a "best available evidence" policy in 2006 instructing plans to update their LIS information when certain documentation of LIS status is provided. Medicare updated this policy in June 2007.

According to this policy, Plans must accept certain proof of LIS eligibility from individuals who have not been identified as dual eligibles by Medicare. Plans must update their records based on this evidence so that individuals are charged the appropriate premiums and co-pays. Dual eligibles who have Part D coverage but who are not identified by their Part D plan as receiving a full LIS (includes reduction or elimination of premium, elimination of the deductible and donut hole, and reduced co-pays of $1/$3.10 or $2.15/$5.35) can contact their Plan and submit documentation to show Medicaid status as proof of eligibility for the LIS. The policy outlines the documentation plans are required to accept such as a copy of the MA eligibility notice or a screen print from the State Medicaid system showing Medicaid status.

This policy also directs Plans to update their records to show zero Part D cost-sharing for institutionalized individuals based on documentation submitted by the facility or documentation from Medicaid showing institutional status. In addition, plans must accept copies of the Social Security Award Letter to update records for non dual eligibles who are awarded a full or partial subsidy.

If dual eligibles are having problems with LIS delays and/or having their Plan update their LIS status, please contact our HELPLINE at 1-800-274-3258 or 1-866-236-6310 (TTY). This policy will be posted on our website (www.phlp.org) shortly.

New Information Posted on PHLP's Website!

Please see our website (www.phlp.org) for many new updates, including the following new and downloadable publications:

- Understanding the PACE Program
- Low-Income Subsidy (LIS) Tri-Fold Brochure in English
- Low-Income Subsidy (LIS) Tri-Fold Brochure in Spanish
- Dual Eligibles Access Manual (updated)

Este anuncio puede ser libremente presentado o distribuido.

PHLP
Pennsylvania
Health Law Project

EN ESPAÑOL!
Medicare y Medicaid: Como Ayudar a Gente Mayor de Edad y de Bajos Recursos
Medicare and Medicaid Eligibility For Low-Income Seniors
(This presentation is in Spanish only!)

La elegibilidad de doble elegibles para programas como el Medicare Savings Program, Subsidios de Medicare, y Programas de Apoyo en el Hogar.

Martes/Tuesday, 11 Septiembre/September, 2007
9:30 -11:30 AM
Philadelphia

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1101 Market Street—11th Floor
Philadelphia, PA

Nota: Es recomendado llegar temprano y traer identificacion con foto para pasar por la seguridad del edificio/Arrive early and Bring Photo ID to get through Building Security

Suicide Prevention Conference

The Office of Mental health and Substance Abuse Services (OMHSAS) in conjunction with Consumer Satisfaction Services and the Departments of Aging and Health are sponsoring a day- long conference – "**Suicide Across the Age Span: Saving Lives Together".** The conference will enable participants to: cite the prevalence of suicide in PA and across the country; recognize leading risk and protective factors that affect suicide; identify special populations at risk for suicide; define what constitutes best practice for a suicide prevention program; list at least one best practice for each level of prevention, treatment and aftercare; and examine the effect of suicide on co-workers and family members and how to respond to them.

The target audience for this conference includes teachers and school personnel, counselors, county health and mental health staff, corrections personnel, juvenile justice staff, survivors of suicide and the general public. The conference includes a keynote address by Jerry Reed, Executive Director of Suicide Prevention Action Network (SPAN USA) and several workshops including "Suicide in the Elderly" and "Survivors Tale".

The Suicide Prevention Conference will be held on Wednesday, September 12, 2007 at the Holiday Inn Harrisburg/Hershey in Grantville. Continuing Education Credits are available. The Conference fee is $25. To register or obtain additional information on the conference contact Joann Roesner at Drexel University at 215-831-7804 or by email at jroesner@drexelmed.edu.

Hospital Discharge Notice Now Required for All Medicare Beneficiaries

Starting July 1, 2007, every Medicare consumer who is admitted to a hospital for an inpatient stay will receive a notice from Medicare. This notice, titled "Important Message from Medicare", will explain the consumer's rights at the hospital, how to appeal a hospital discharge to the Quality Improvement Organization (QIO), and how to file a complaint concerning quality of care at the hospital with the QIO. Contact information for the QIO must be included in the notice.

The consumer must receive the Important Message from Medicare notice within 2 days from the date of hospital admission. The consumer is required to sign and date the notice upon receipt to ensure that the notice was delivered. The client will receive another copy of the same notice two days before being discharged from the hospital to remind them about their rights and give them information about how to appeal the hospital's decision to discharge.

Extensive information is available on the website of the Center for Medicare Advocacy at http://www.medicareadvocacy.org/Hospital_NewDischargeRuleDetails.htm. Additionally, CMS guidance can be found through a search at www.cms.hhs.gov.

Medicare Part D: Enrollment Information Update

In recent months, there have been important developments in regard to Medicare Part D enrollments. These developments are:

All Medicare Part D LIS Individuals Now Get An Ongoing Special Enrollment Period (SEP)

Effective June 20, 2007, any Medicare beneficiary who qualifies for the Low-Income Subsidy to help them with Medicare Part D costs (but who is not a dual eligible) now qualifies for an ongoing Special Enrollment Period (SEP). **This SEP allows all LIS-eligible individuals to change their Part D Plan at any time.** Previously, individuals who were non dual eligibles and qualified for the LIS were limited to one Plan change during the year and this was only if Medicare facilitated their enrollment into a Plan. Now, LIS-eligible individuals can change plans on a monthly basis. This SEP begins the month that an individual is found eligible for the LIS and remains in effect as long as she continues to qualify for the LIS. Plan changes become effective the first of the month after the Plan receives the enrollment request.

Medicare Establishes New "Exceptional Circumstance" Special Enrollment Period

Last month, the Centers for Medicare & Medicaid Services (CMS) announced a new SEP to address situations where someone enrolled in a Medicare Advantage Plan based on misleading or incorrect information provided by plan employees, agents, or brokers. Individuals who enrolled in Medicare Advantage Plans under these circumstances can contact 1-800-MEDICARE (1-800-633-4227 or 1-877-486-2048 (TTY) to request this SEP. Medicare representatives will grant these requests on a case-by-case basis. If individual's requests are granted, Medicare will help these beneficiaries enroll in another plan option (if needed). Individuals seeking retroactive enrollment changes should note this when requesting this SEP.

If you have questions about these Special Enrollment Periods or if you are having problems regarding these SEPs, please contact the PA Health Law Project Helpline at 1-800-274-3258 or 1-866-236-6310 (TTY).

PHLP staff are available in Southeastern PA to conduct trainings on Part D related issues to help social service agencies and their clients navigate their dual eligibles healthcare coverage. Trainings focus on eligibility for Medicare Savings Programs and the Low-Income Subsidy, healthcare access for dual eligibles, the rights that dual eligibles have under Part D and the appeals and grievance processes that are available to all Part D enrollees.

To learn how to help get your clients' needs met through Medicare Part D, 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 persons with hearing and/or vision needs.

CHAMP Act Provisions to Help Low-Income Medicare Beneficiaries

Congress is currently debating the Children's Health and Medicare Protection (CHAMP) Act. This legislation includes numerous protections for low-income Medicare beneficiaries and expands programs that help low-income Medicare beneficiaries with their Medicare cost-sharing. This legislation was passed by the US House of Representatives on August 1, 2007 (H.R. 3162). To become law, it would need to be passed by the US Senate and signed by the President.

Some of the protections and expansions for low-income Medicare beneficiaries included in the CHAMP Act are:

-**Increasing the asset limit for Medicare Savings Program and Low-Income Subsidy Program** to $17,000 for an individual and $34,000 for a married couple (with annual increases to these limits starting in 2010). Currently, the asset limit to qualify for the Medicare Savings Program is $4,000 for an individual and $6,000 for a married couple.

-**Expanding the income limits for the Qualified Individual (QI) program that helps pay Medicare Part B premiums for qualified low-income persons**. Currently, individuals must have income between 120-135% FPL ($1,021-$1,149/month for individual and $1,369-$1,540/month for couple in 2007) to qualify for this help. The CHAMP legislation would raise the income level to 150% FPL. This provision also would make this program permanent. Currently, the QI program is due to end on September 30, 2007. Individuals with incomes below 120% FPL qualify for help with their Part B premium payment under another program.

-**Eliminating Part D cost-sharing for certain individuals who receive care through a Home and Community Based Waiver**. Currently, institutionalized individuals who are full benefit dual eligibles do not have any Part D co-pays, but individuals who live in the community have to pay co-pays between $1 and $5.35 per medication. This provision would expand this zero Part D cost-sharing for individuals who require a nursing facility level of care but who chose to remain in the community and receive benefits through a Home and Community Based Waiver Program.

-**Disregarding certain income and resources when determining eligibility for the Part D low-income subsidy.** Under this provision, life insurance and balances on retirement accounts would no longer be counted in determining eligibility for the subsidy. In addition, in-kind support and maintenance income would no longer be counted.

-**Eliminating the Part D Late Enrollment Penalty for Beneficiaries Approved for the Low-Income Subsidy**. In 2006 and 2007, Medicare has waived the late enrollment penalty for individuals who qualify for the LIS (if they did not sign up for Part D during the initial enrollment period and did not have creditable coverage). This provision would make this policy permanent.

-**Assigning low-income beneficiaries to Part D Plans that best meet their needs**. Currently, Medicare enrolls full benefit dual eligibles and beneficiaries approved for the LIS into Part D plans if the individual does not enroll in a Plan on their own. This enrollment is done randomly

(continued from Page 9) *(Continued on Pate 10)*

among all of the zero-premium (with a full subsidy) plans available. This provision would have Medicare assign individuals to plans most likely to cover their drugs and to have pharmacies accessible to them.

-**Capping out-of–pocket spending under Part D to 5 percent of income annually for the lowest income Medicare beneficiaries** to ensure that the poorest Medicare beneficiaries are not financially wiped out by their Part D cost-sharing.

This Act includes many other important provisions for Medicare beneficiaries such as parity for mental health co-insurance (increasing the Medicare reimbursement rate for outpatient mental health treatment from 50% to 80%), allowing individuals to change Part D plans when their plan changes their formulary to no longer cover a medication or increase cost-sharing (currently individuals are locked-in to their Plan and cannot change during the year unless they qualify for a Special Enrollment Period), and extending and revising the authority for Medicare Special Needs Plans (such as requiring SNPs for dual eligibles to coordinate with the state Medicaid program).

Stay tuned to future editions for an update on this legislation or other legislative efforts impacting Pennsylvania's seniors.

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