# SENIOR HEALTH NEWS

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Volume 9, Issue 6

December 2007


## State's Aging Waiver Standard Continues to Await Fixing

Since mid-2006, a significant number of individuals who had been receiving services through the Pennsylvania Department of Aging (PDA) Waiver were terminated due to a tightening of the "Nursing Facility Clinically Eligible" (NFCE) standard. The bulk of the terminations occurred in Philadelphia County. Most of the affected consumers had been receiving waiver services for a number of years and had experienced either no change or deterioration in their condition prior to being determined to no longer meet the NFCE standard. In addition to those terminated from services, there is reason to believe some unknown number of consumers has been wrongfully denied an initial request for such services due to the tightening of the NFCE standard. This has been happening in a year when the Aging Waiver budget is reportedly $90 million under spent.

As stated by administration personnel, the Nursing Facility Clinical Eligibility standard was revised as part of an effort to apply the same rules statewide. However, the language used had the effect of eliminating coverage for persons who require intermediate care, and limiting coverage only to persons with skilled care needs. Federal Medicaid law requires the state to cover both the intermediate **and** skilled levels of care in their Medicaid HCBS waivers such as the Aging Waiver. PHLP staff and other advocates have repeatedly met with officials in the Office of Long Term Living (OLTL) in attempts to address this ongoing issue.

As a result of these meetings, OLTL reviewed the files of nearly 500 individuals who were terminated from the waiver between January 2006 and July 2007 as no longer meeting the NFCE standard. The state agreed to reinstate waiver benefits for a significant number of individuals who upon review were found to: (1) have no changes in their condition or (2) have improved as a result of getting services through the Options Program (after the termination of waiver services) but who would likely decline again in the absence of services. It is not clear whether these reinstatements have yet occurred.

OLTL has also agreed to revise the standard to reinstall the required intermediate level of care requirements. However, this has not yet occurred. The State continues to use the unlawfully stricter definition of NFCE. PHLP and other advocates have continue to press the state to issue an immediate clarification to the Area Agencies on Aging and the public about the fact that individuals can be determined NFCE if they have an **intermediate or skilled level of care**.

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PHLP has been representing individuals who have been terminated from or denied an initial request for the waiver on these grounds and continues to raise concerns with the state about the need to correct the NFCE standard.

In summary, individuals who need the **intermediate or skilled** level of care should be determined NFCE in order to qualify for services through the Aging Waiver. Consumers and advocates should contact PHLP's Helpline regarding cases where individuals in need of in-home supports are being denied waiver services or are terminated from the waiver. PHLP's Helpline number is 1-800-274-3258 or 1-866-236-6310/TTY.

**The Aging Waiver is due to be renewed in 2008. The Office of Long Term Living will be holding "listening sessions" around Pennsylvania in early 2008 to obtain feedback about how the waiver is working and hear suggestions about how the program can be improved. Check our website (www.phlp.org) to find out when and where the listening sessions will take place!**

# Assisted Living Update

Stakeholders appointed to the Department of Public Welfare's Assisted Living Workgroup have begun meeting to discuss the development of the Assisted Living Regulations the Department must promulgate.

Act 56 of 2007 requires the DPW to license and regulate Assisted Living Facilities. The regulations are required to be developed with stakeholder input. Facilities that currently call themselves Assisted Living are licensed as "personal care homes" which are designed for individuals who require limited assistance with daily activities. Assisted Living is intended to serve both consumers who require limited assistance with daily activities as well as those who require more extensive assistance or even skilled care. Under Act 56, the regulations for Assisted Living Facilities must meet or exceed the existing personal care home regulations. Additionally, no facility will be allowed to call itself Assisted Living until such time as it meets all the requirements of the new Assisted Living regulations that will be issued.

The DPW Workgroup has met regularly since October to help DPW craft the regulations, with particular focus on how the Assisted Living Regulation requirements should exceed the requirements for Personal Care Homes and on how new topic areas articulated in Act 56 (that are not topics in the personal care home regulations) should be handled in the regulations.

As of the end of 2007, there has been some, but not complete, workgroup discussion of the following topics: Staff and Administrator Qualifications and Training, Residents Rights, Waivers, Grandfathering, Living Units, Kitchenettes, Lockable Doors, Excludable Conditions, and Informed Consent. The meetings are open to the public. The January 2008 meeting dates are January 8, January 15, and January 29 from 12:30-3:30 at the Department of Education building at 333 Market Street in Harrisburg.

# Medicare Private Fee-For-Service Plans: What You Need to Know

The number of Medicare Private Fee-For-Service (PFFS) plans available in PA is growing rapidly. In 2007, there are 86 PFFS plans available in PA. In 2008, there will be 191 PFFS plans available in PA. Some plans are available statewide while many of them are only available in certain counties across PA. Medicare Private Fee-For-Service plans are a type of Medicare Advantage plan available to individuals with Medicare. Beneficiaries who join this type of plan get their Medicare Part A and Part B covered services through the PFFS plan. The PFFS plan may also cover extra benefits that Original Medicare does not cover (i.e., vision or hearing benefits).

Over the last year, there have been numerous concerns raised about PFFS plans, especially in regards to the marketing of these plans. Medicare beneficiaries around the country reported signing up for PFFS plans based on misleading statements from sales representatives only to find out they could no longer see their providers or they had to pay higher out of pocket costs for services and coverage. So, before you decide whether to join this type of plan, here's what you need to know:

**ACCESS**

Many of these plans do not have provider networks and members can go to any Medicare provider for care; however, Medicare providers are not required to accept the PFFS plan's terms and conditions and can refuse to see people in PFFS plans. PFFS plans, unlike other Medicare Advantage plans, are not required to have agreements with a minimum number of providers in an area to guarantee access to care. Providers can decide whether to accept the PFFS plan payment, and they can decide differently for each visit. It is important that members of these plans ask their providers whether they accept the plan's fees and terms and ask this every time they get services.

**COSTS**

Medicare PFFS plans can charge a premium for their coverage (which is in addition to an individual's Medicare Part B premium). There is no limit on the amount the PFFS plan can charge for its premium. Furthermore, plans can charge extra premiums for supplemental coverage (like prescription drugs, vision, hearing, dental). PFFS plans are allowed to charge different deductibles and coinsurance than the Original Medicare program. By law, PFFS plans have to provide a notice of anticipated cost-sharing for hospitals, but not other services. These plans are not required to pay Medicare standard rates to providers nor do they need to submit their rates and premiums to the Centers for Medicare & Medicaid Services (CMS) for review.

**DRUG COVERAGE**

PFFS plans are not required to offer Part D coverage. Unlike members of other types of Medicare Advantage plans who have to get their Part D coverage as part of their plan's benefit package, members of PFFS plans that do not offer Part D coverage can get their prescription coverage through a stand-alone Prescription Drug Plan (PDP). For plans that do offer drug coverage, they are not required to submit negotiated drug prices to CMS nor are they required to established programs (like Medication Therapy Management Programs) aimed at lowering the chance of adverse events.

While PFFS plans may work for some Medicare beneficiaries, they do not work for everyone. In general, individuals with both Medicare and Medicaid do not benefit from joining these types of plans. More information about PFFS plans can be found at www.medicareadvocacy.org.

## Medicare Advantage Open Enrollment Period Starts January 1, 2008

Medicare beneficiaries have another opportunity to change plans in 2008 after the end of the current Annual Open Enrollment Period on December 31, 2007. Every year from January 1st until March 31st, Medicare beneficiaries who are enrolled in a Medicare Advantage plan can change their plan or go back to Original Medicare. Similarly, individuals in Original Medicare can join a Medicare Advantage plan during this period.

During this Medicare Advantage Open Enrollment Period, Medicare beneficiaries can only change from "like plan to like plan". This means that if someone is currently in a Medicare Advantage plan with prescription drug coverage (MA-PD), they can only change to another MA-PD or go back to Original Medicare and join a stand-alone Prescription Drug Plan (PDP). Individuals who are enrolled in Medicare Advantage Only plan (with no drug coverage) would be limited to joining a different Medicare Advantage-only plan or going back to Original Medicare. These individuals would not be able to pick up Part D coverage through an MA-PD or a PDP during this enrollment period.

Not all Medicare Advantage plans accept enrollments during this Open Enrollment Period. If people do make changes during this period, their coverage should become effective the first of the following month.

## Medicare Part B Open Enrollment Period Also Starts January 1st

Medicare beneficiaries who have not yet joined Part B can do so between January 1st and March 31st of every year. Part B coverage for those individuals who enroll during this period will start July 1st. Individuals who did not join Part B when it was first offered to them may have to pay a penalty of 10% for every year that they waited to join Part B. The Part B premium for 2008 will be $96.40 per month for most individuals. Individuals with high incomes (over $80,000 per year for a single person or $160,000 per year for a married couple) pay a higher Part B premium.

Individuals with income under 135% FPL ($1,149/mo for a single person and $1,540/mo for a married couple) and resources below $4,000 for a single person and $6,000 for a married couple can qualify for the Medicare Savings Program (MSP) and have the State pay their Medicare Part B premiums for them. Individuals who do not currently have Part B coverage but who qualify for The Medicare Savings Program will be enrolled in Part B after being approved for the MSP benefit. Generally, it takes 2-3 months before the Social Security Administration and Medicare systems are updated; once this happens, the individual will be enrolled in Part B. In addition, these individuals are not subject to the Part B penalty. Please call PHLP's Helpline for more information about the MSP benefit (1-800-274-3258 or 1-866-236-6310/TTY).

## 2008 Part D LIS Resource Limits Announced

The 2008 resource limits to qualify for a Low-Income Subsidy (LIS) (also called "extra help with Medicare prescription drug costs") are **$7,790** (**$12,440** if married) for the **full low-income subsidy** and **$11,990** (**$23,970** if married) for a **partial low-income subsidy**. In 2007, the resource limits for the full subsidy are $6,120 ($9,190 if married); the partial subsidy limits are $10,210 ($20,410 if married).

CMS will release the 2008 income standards for the LIS in early 2008 after the release of the 2008 federal poverty levels (FPL). We will share that information with you after it becomes available.

# SAMHSA Awards Grant to Pennsylvania to Enhance Transformation of Mental Health System: Focus to be on Older Adults

In a press release on December 11, 2007, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced that 10 states and Puerto Rico were awarded funding for pilot programs to enhance transformation of their mental health systems. Pennsylvania was one of the 10 states selected for this "Transformation Transfer Initiative" funding and will receive an award for up to $105,000 for one year.

The Transformation Transfer Initiative will support new and expanded efforts to improve the capacity and effectiveness of mental health systems that foster recovery and meet the multiple needs of consumers. The pilot programs will also explore new ways of getting mental health care services to everyone in need which is "a critical public health challenge" according to SAMHSA.

Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) within DPW submitted a proposal to support PA's transformation agenda. The Older Adult Committee of the OMHSAS Advisory Committee has identified the development of Older Adult Peer Specialists as a priority goal of the committee and identified this as the focus of the project submitted to SAMHSA. Studies support that 10-30% of older adults nationwide have a mental health disorder but older adults are less likely to seek treatment from behavioral health specialists because of stigma. Pennsylvania has the third highest percentage of older adults in the nation. Older adults with behavioral health disorders who do not seek treatment are at increased risk of hospitalization, reduced physical functioning, suicide, and mortality from other causes.

Older Adult Peer Specialists are trained and certified individuals, age 50 and older, who self-identify as consumers of mental health services. Since November 2006, Peer Support Specialists Services are reimbursable by the PA Medical Assistance program. With this SAMHSA grant award, OMHSAS will develop training programs for individuals to become Older Adult Peer Specialists. There will be two training programs: an "Older Adult Peer Support Competent" 1-day curriculum and an "Older Adult Peer Support Enhanced" 3-day curriculum. OMHSAS will then recruit and train 100 Peer Support Specialists (age 50 and older) with the goal of 80 of them trained in the competency curriculum and 20 trained in the enhanced curriculum. The enhanced curriculum will provide a specialization for Peer Specialists who are interested in focusing their work with older adults. One goal of this project is to create specialized workforce opportunities and career ladders for the certified peer specialists who complete the Enhanced Older Adult Curriculum.

The OMHSAS timeline for this project includes development of both curricula by February 2008 and completion of the Older Adult Competent Training and the Older Adult Enhanced Training by the end of July 2008. Bill Boyer, Section Chief for Program Development in OMHSAS is the PA OMHSAS Coordinator for this project. Certified Peer Specialists aged 50 and older who want to participate in either training program can contact Bill Boyer at wboyer@state.pa.us for more information.

# Long-Term Care Partnership Programs: New Law for PA

The name alone does not clearly convey what is meant by the term "long-term care partnership program". The programs, however, are interesting and now part of the law in Pennsylvania. The idea behind long-term care partnership programs is that consumers are encouraged to purchase long-term care insurance to help pay for the cost of their long term care. In return, they are able to "protect" assets up to the value of the long-term care insurance policy.

For example, if an older adult has a $150,000 long-term care insurance policy that is a partnership policy, then once she uses $150,000 of long term care paid for by the policy, she can qualify for Medicaid even if she has up to $150,000 in assets. Usually, in order to qualify for Medicaid coverage of a nursing home, a person's resources have to be less than $2,400; to qualify for a Medicaid Home and Community Based Services waiver program, a person's resources have to be less than $8,000. In this example, having $150,000 in assets would, in usual circumstances, disqualify her from Medicaid eligibility; however, with a long-term care partnership policy, the $150,000 in assets will be protected and will not count toward her countable assets in establishing her Medicaid eligibility.

Long-term care partnership programs have been pilot-tested in many places. Several states have recently enacted laws enabling these programs to work more smoothly for consumers and insurers. Pennsylvania passed a law this summer, Senate Bill 548, Act 40, creating a Long Term Care Partnership Program for Pennsylvania. This law follows some changes made by Congress in 2006 in the Deficit Reduction Act ("DRA") of 2005. The DRA established some consumer protections and changes to state Medicaid rules around estate recovery that facilitate states to try partnership programs.

Act 40 directs the Department of Public Welfare to file a Medicaid state plan amendment with the federal Centers for Medicare & Medicaid Services that creates a partnership program which satisfies the federal requirements, as established by the DRA. DPW filed a state plan amendment and further implementation steps are anticipated in the months ahead.

Among other things, consumers who purchased long term care insurance policies since the adoption of the DRA are supposed to be able to exchange those policies for "qualified" policies under the partnership program.

Nationwide, a limited number of consumers have purchased long-term care insurance. Some individuals report having trouble getting an insurer to cover them due to a preexisting condition while others report facing different obstacles to obtaining coverage like the price being out of reach. There is no clear sense that the Partnership programs aim of encouraging people to purchase long term care insurance will be realized. PHLP will continue to follow this issue and will update you in future editions of the Senior Health News. You can read Act 40 (SB 548) at www.legis.state.pa.us.

## Reminder About Medicare Part D Transition Rules

In January, Medicare beneficiaries may have problems getting medications at the pharmacy if their Part D plan's formulary has changed for 2008 or if they are enrolled in a new Plan and find that a medication they need is not covered by their new plan. As a reminder, Part D plans are required to have a transition process in place that allows for a one-time fill of a medication that is not on the formulary or requires prior authorization or step therapy. The one-time fill must be for a 30 day supply and must be provided at any time during the member's first 90 days of coverage.

Individuals whose medication is not on their plan's formulary will then have to seek a formulary exception from their plan in order to refill the prescription after the one-time fill. Likewise, if a medication requires prior authorization or step therapy, then the member's doctor will have to request prior authorization or submit information showing that the member cannot take another medication in order for the plan to continue covering the medication beyond the one-time fill. Members can contact their Part D plan to find out what steps they need to take to get a formulary exception or get prior authorization for their medication.

Individuals also have the option of talking to the doctor about changing to a medication that is on the plan's formulary or one that does not require prior authorization or step therapy. Individuals who also qualify for a Special Election Period (such as people with both Medicare and Medicaid and individuals who qualify for the low-income subsidy) can decide whether they want to join a different plan for ongoing coverage.

If dual eligibles or others who qualify for the low-income subsidy have problems getting medications through Part D when they go to the pharmacy for the first time in January 2008, please call the PHLP Helpline at 1-800-274-3258.

## Proposed Standards for Medicare Special Needs Plans

The Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) have announced proposed quality measures for Medicare Advantage Special Needs Plans (SNPs). As we have previously reported, there is great concern about the lack of standards and requirements across Medicare SNPs. Uniform standards established by CMS would significantly improve the quality of care and access to services of special needs individuals who belong to SNPs. While many believe the proposed quality measures are not enough, it might help reveal information that could then persuade CMS and others of the need for developing defined standards of how SNPs must meet consumers' needs. The proposed standards can be viewed and comments to them can be submitted by January 16th through the NCQA website at this address: http://web.ncqa.org/tabid/620/Default.aspx.

Are you an advocate or provider working with dual eligible clients over 60 years old in Southeastern PA who wants to stay up to date on Part D developments? Join the PHLP e-mail list serve! To join, e-mail staff@phlp.org with subject "join Part D list serve".

PHLP staff are also available in SE PA to conduct trainings on Part D related issues to help social service agencies and their dual eligible clients navigate their healthcare coverage. Trainings focus on eligibility for Medicare Savings Programs and the Low-Income Subsidy, healthcare access for dual eligibles, rights of dual eligibles under Part D, and the appeals and grievance processes. Contact the PHLP Helpline to schedule a training at 1-800-274-3258 or 1-866-236-6310/TTY.

# TRICARE For Life

Persons with Medicare usually need some additional, supplemental coverage to help them with their Medicare cost-sharing. While previous issues of the Senior Health Newsletter have discussed how Medigap policies and Medicaid coverage fill in the gaps in Medicare's coverage, we wanted to also provide some information to our readers about the TRICARE For LIFE (TFL) program. TRICARE for LIFE provides secondary insurance for retirees of the uniformed services and their family members who have Medicare.

TRICARE is the health care program for active duty service members of the uniformed services, retirees, and their family members. Uniformed services include the US Army, Air Force, Navy, Marines, Coast Guard, the Commission Corps of the Public Health Service, and Commission Corps of the National Oceanic and Atmospheric Association. TFL is available to all Medicare-eligible TRICARE beneficiaries, regardless of age, including retired members of the National Guard and Reserve who are in receipt of retired pay, family members, widows and widowers and certain former spouses.

To be eligible for TRICARE for Life, individuals must have both Medicare Part A and Part B. Enrollment in TRICARE for LIFE is automatic once an eligible individual's Medicare Part A and B coverage is registered in the Defense Enrollment Eligibility Reporting System. Medicare provides this information on a monthly basis for individuals age 65 and older and every three months for individuals under age 65.

TFL acts as a second payer to Medicare for benefits payable by both, and pays for Medicare deductibles and cost sharing. TFL beneficiaries can go to any Medicare provider for care. Claims will be sent automatically to TRICARE after Medicare has paid its portion. Enrollees are required to pay the Medicare Part B premium, but there are generally no additional costs for services that are covered by both Medicare and TRICARE for LIFE.

When paying for services covered by Medicare and not by TFL, such as chiropractic care, Medicare will pay its part and then the recipient is solely responsible to pay for the Medicare deductibles and cost sharing for that visit. For services that are not covered by Medicare but are covered by TFL, such as care overseas, TFL will be the primary payer and the recipient is responsible to pay TRICARE deductibles and cost-sharing.

More information about TRICARE for LIFE benefits can be found at http://www.tricare.mil/mybenefit.

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# Update on Shingles Vaccine and Part D

Although Zostavax®, a vaccine to prevent herpes zoster or shingles, is recommended for everyone over 60 years old, it remains very difficult for Medicare beneficiaries to receive the vaccine because of reimbursement problems. According to the Medicare Modernization Act of 2003, all new vaccines are reimbursed under the Medicare Prescription Drug Benefit (Part D). Older vaccines usually given to the Medicare population, such as flu shots or pneumonia shots, are paid for by Medicare Part B. Zostavax®, is the first new vaccine to be covered under Part D.

Physicians are not providers under Medicare Part D, so doctors' offices cannot buy the vaccine from suppliers and charge the patient for the vaccine and its administration. Only pharmacists can bill Medicare D plans. Although doctors could give patients a prescription for the vaccine, have the patient take it to a pharmacy, and return with the vaccine to the office, this is impractical for most situations. The vaccine is frozen and must be given within 30 minutes of defrosting.

In 2007, Congress passed a special provision that allowed doctors to bill for giving the vaccine, if the consumer was able to buy it from a pharmacy. However, this provision has not been renewed for 2008. Instead, the Part D plan is supposed to pay for the vaccine and the administration of the vaccine. However, as already noted, physicians cannot bill Part D plans.

Because the vaccine is expensive, doctor's offices generally do not order and stock the vaccine even though many insurances including Pennsylvania Medical Assistance do reimburse physicians who administer the vaccine for consumers between 60 and 64 years old.

**What should you do if you want the vaccine, or if your doctor offers you the vaccine?** Take some time to investigate your situation before ending up with a bill. If you are a consumer and a physician recommends the Zoster/ shingles vaccine, find out if your Medicare Part D plan (or other insurance plan if you're not on Medicare) will cover it. Call the plan and confirm the information, and note the name of the person with whom you are speaking. Ask if they use a specialty pharmacy (see below) or if you can take a prescription to a regular pharmacy.

If you are on Medicare D and you receive the vaccine from your physician, the physician will most likely charge you for the vaccine and ask you to submit out-of-network paperwork for reimbursement. The vaccine can cost between $150 and $190. You will need to get reimbursement from your Medicare D plan. You are unlikely to be reimbursed the full cost of the vaccine, because you will be responsible for co-payments.

You should find out how much your plan charges for the vaccine (i.e., find out what level or tier it is on). In most Pennsylvania Part D plans, Zostavax is on Tier 2 or 3. Many plans have co-pays of $25-$50 for Tier 3 drugs. If you are in the "doughnut hole" or have not met a deductible, you could be responsible for the entire amount, which could range from $150 to $190. Remember, low-income individuals who qualify for a subsidy pay either a $3.10 or $5.60 co-pay or 15% of the drug costs and are not subject to the donut hole.

Some Medicare D plans have agreements with "specialty pharmacies" to supply high cost injectable drugs. If this is true of your plan, your doctor can write a prescription for you for the vaccine, send it to the specialty pharmacy, and the pharmacy will deliver the drug to your doctor's office. Then you need to return to the office to get the vaccine. The specialty pharmacy will bill your Medicare D plan and arrange for the physician to be paid to give you the

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vaccine. Your Medicare D plan should be able to give you this information if the physician's office is not familiar with the procedure.

In Pennsylvania, pharmacists can be certified to administer vaccines. As of December 2007, over 600 Pennsylvania pharmacists are certified and are carrying the vaccine. That means your doctor could give you a prescription and the pharmacist can give you the shot. However, you will still be responsible for your co-pay. The pharmacist should be able to tell you your cost before you make a decision.

As of January 2008, some physician practices that have electronic prescribing may be able to use a new commercial company that will allow the doctor to buy the vaccine and administer it, and be paid via this new company. However, it is anticipated that only a small number of practices will have this in effect during the upcoming year.

As the year ends, we take a moment to wish all our readers a healthy new year! PHLP is a small non-profit 501(c)(3) law firm. We encourage you to consider us when you are making any year-end contributions to charitable organizations.

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