SENIOR HEALTH NEWS

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PA Consumers Help Halt Medicare SNP Growth

The uncontrolled growth of Medicare Advantage Special Needs Plans (SNPs) is being curbed. In late December 2007, Congress and the Bush Administration agreed to extend the authorization for SNPs beyond 2008. However, the Medicare, Medicaid, and SCHIP Extension Act of 2007 only extended the authorization for Special Needs Plans through 2009 and passed a moratorium on Special Needs Plans.

The moratorium prohibits the addition of new SNPs and limits existing SNPs to the types, subsets, and service areas that were approved prior to January 1, 2008. The moratorium does permit continuing enrollment in existing SNPs through December 31, 2009. The Centers for Medicare & Medicaid Services (CMS) are prohibited from approving any new SNP applications or any service area expansions for 2009. Congress has begun to hold hearings and to review SNP performance and will need to decide whether to authorize SNPs beyond 2009 and, if so, what requirements to impose on SNPs to ensure that they meet the special needs of the populations they enroll.

Medicare Advantage SNPs were first authorized by the Medicare Modernization Act of 2003 as managed care plans that could target special needs populations. The special needs populations subject to targeting were: 1) dual eligibles, 2) institutionalized individuals, or 3) individuals with severe chronic conditions. In 2004, there were 11 SNPs approved nationally. In 2005, there were 125. In 2006, there were 276. In 2007, there were 477. In 2008, there are 775 SNPs nationally. There are 29 Medicare Advantage Special Needs Plans in PA for 2008.

Because of Pennsylvania's experience with passive enrollment in early 2006, Pennsylvania consumers were well positioned to report how SNPs were serving their needs. Passive enrollment caused very large numbers of Pennsylvania's dual eligibles (over 110,000) to be forcibly enrolled out of traditional Medicare and into Medicare managed care, specifically into 6 Medicare Advantage Special Needs Plans. As we have discussed in prior editions, dual eligible SNP enrollees have repeatedly called PHLP for assistance with barriers they faced accessing prescribed care from their SNP. Complaints and concerns have been raised with CMS that SNPs for dual eligibles:

1) have providers who refuse to accept Medical Assistance (Medicaid);

2) have providers that balance bill Medicaid recipients for amounts unpaid by the SNP;

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3) are not instructing providers about what Medicaid will cover for their patients;

4) are not informing pharmacies of what Medicaid will cover or requiring them to bill the Medicaid program for covered drugs;

5) are not informing enrollees that Medicaid might cover a service that the SNP doesn't;

6) 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) through Medicaid; or

7) are providing inaccurate information about what Medicaid does cover.

PHLP presented the beneficiary experience to several national audiences in 2007. PHLP was also commissioned to author and present a paper on the Pennsylvania Beneficiary Experience for a conference of key stakeholders convened by the Center for Medicare Advocacy (CMA). The conference (sponsored by The Commonwealth Fund) produced a number of critical recommendations for Medicare Advantage SNPs that were recently published.

CMA's recommendations and a copy of PHLP's conference paper is available at CMA's website (www.medicareadvocacy.org) with an updated version of the paper available through the www.phlp.org website. Additionally, Alissa Halperin of PHLP co-authored two law review articles to be published on SNPs, which can also be viewed from our website. PHLP continues to share with national experts and policymakers the consumer experiences that prompt a need for SNP reforms.

PHLP continues to assist SNP enrollees with problems accessing care and welcomes client calls to our toll-free helpline at 1-800-274-3258 and 1-866-236-6310/TTY.

Governor Announces Proposed 2008-2009 Budget

Governor Rendell announced his proposed 2008-2009 budget to the PA General Assembly on February 5th. The Governor proposes to expand certain services and avoid cuts to Medical Assistance eligibility or services. Improving the long-term care system continues to be a focus of the administration's efforts to meet the demands of PA's aging population in a cost-effective way while promoting consumer choice and improving the quality of care.

The 2008-2009 proposed budget includes the following recommendations of particular interest to older adults and the professionals that work with them:

- Funding to serve an additional 2,100 individuals in the Aging Waiver;
- Increased funding to expand community-based long-term living options;
- $332.1 million increase for the PACE Plus Medicare program to serve an additional 24,000 older adults;
- $3.1 million to increase the availability of adult day care services; and
- $1.3 million in administrative resources to begin licensing, certifying and inspecting assisted living residences (see page 10 for more information about assisted living developments).

Please see our website (www.phlp.org) for more information about the 2008-2009 proposed budget. Detailed information about the proposed budget can be found on www.state.pa.us.

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Retired State Employees Face Major Change to Their Health Coverage

Retired state employees who are covered by the Pennsylvania Employees Benefit Trust Fund (PEBTF) were recently informed that their health care benefits are changing effective May 1, 2008. Essentially, these retirees will now be required to enroll into a Medicare managed care plan (also called a Medicare Advantage plan). **The deadline for enrollment is March 22, 2008.** In order to choose the Plan that would be best for them, PEBTF retirees need to understand and investigate the health plan choices available to them in their county.

Up until now, most retired state employees have been in Traditional Medicare (using their red, white and blue Medicare card) which allowed them to obtain care from any provider in the state who accepted Medicare. The PEBTF program supplemented that coverage with a Medicare Supplement, a Major Medical Benefit, and a REHP Prescription Drug Plan. In recent years, retirees were also given the choice of enrolling in a Medicare Advantage Plan-either a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO). Retirees who chose this option received all of their health coverage through their HMO or PPO.

The PEBTF has now decided to change its program and require that all retirees who want to retain their PEBTF benefits must enroll in a Medicare Advantage Plan. Though retirees have a number of plans to choose from (depending on their county of residence), the PEBTF is encouraging its members to enroll in Coventry's Advantra Freedom Medicare Private Fee-For-Service (PFFS) Plan. In fact, those that decline to enroll in a Plan on their own by the deadline will be automatically enrolled in the Advantra Freedom PFFS Plan. Advocates have expressed concern over the state's choice of a Medicare PFFS Plan in which to default retirees who fail to enroll into one of the other Medicare Advantage options. As noted in our December 2007 *Senior Health News*, consumers across the country have reported problems with PFFS plans including misleading marketing tactics used by some Medicare PFFS Plan sales representatives and problems accessing providers who would not agree to the PFFS Plan's terms and conditions.

Plan Choices

State retirees received a notice from PEBTF in January informing them of the upcoming changes and describing their health plan options. Retirees can:

- Choose the Advantra Freedom Medicare PFFS Plan - In this case, the retiree will continue to be in the REHP Drug Plan for prescription coverage;
- Choose a Medicare HMO (the HMO choices vary depending on the county of residence) - In this case the retiree receives all their Medicare and drug benefits through their HMO; or
- Choose a Medicare PPO (the PPO choices vary depending on the county of residence) - In this case the retiree receives all their Medicare and drug benefits through their PPO.

If no choice is made and a retiree is currently in Traditional Medicare, he/she will be automatically enrolled into the Advantra Freedom PFFS Plan. **Note**: those who are auto-enrolled can decline the coverage. In that case, they will be put back into Traditional Medicare and continue to be able to get the REHP Drug Benefit but they will lose their other PEBTF benefits and will have to purchase their own Medicare Supplement Plan.

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Retirees were previously informed that they had until February 22, 2008 to make a choice and that their new plan would go into effect on April 1st. **That deadline has now been extended**. The PEBTF announced that retirees now have **until March 22, 2008** to choose their plan and the new plan coverage will go into effect on May 1, 2008.

Considerations for Choosing a Plan

All PEBTF retirees are encouraged to investigate their Plan options and enroll in the Plan that is best for them. These are some of the things to investigate before choosing a Plan:

- ***Will I be able to continue to see the medical providers who are important to me (i.e. primary care doctor, specialists, hospital, pharmacy) if I join this Plan?***
  Remember, being enrolled in any Medicare Advantage Plan could affect your ability to access medical providers:
  - If you choose a Medicare HMO, you can only go to providers who are in the HMO's network.
  - If you choose a PPO, you can go to providers outside of the PPO's network but you must pay higher costs to access out-of-network providers.
  - If you choose the Advantra Freedom PFFS Plan, you can only see providers who accept the Plan's terms and conditions of payment. PHLP has learned that some health systems do not accept Medicare PFFS Plans. In the Philadelphia area, for example, Main Line Health System announced it would not accept Medicare PFFS Plans and the University of Pennsylvania Health System will not accept new patients who have coverage through Medicare PFFS Plans.

- ***What costs will I incur if I join this Plan?***
  The amount of a retiree's cost-sharing differs from Plan to Plan. Check to see if you will have a deductible as well as the type and amount of co-pays you will incur for various services

- ***Are there any extra benefits offered by the Plan that are important to me?***
  Some Medicare HMOs and PPOs, for example, offer extra coverage for vision care/ eyeglasses, dental care and/or hearing aids

The Enrollment Process

This is the process for those retirees wishing to enroll in a Medicare HMO or PPO:

- If the consumer is currently in Traditional Medicare, she must complete the Plan's enrollment form and mail it to the Plan by March 22, 2008.

- If the consumer is already enrolled in a Medicare HMO or PPO and wants to remain in that Plan, he does not need to do anything. His current coverage will simply continue.

This is the process for those retirees wishing to enroll in Advantra Freedom PFFS Plan:

- If the consumer is currently enrolled in a Medicare HMO or PPO, he will need to complete and Advantra enrollment form and submit it to the Plan by March 22, 2008.

- If the consumer is currently in Traditional Medicare, she does not need to take any action because the PEBTF will automatically enroll her into the Advantra Freedom PFFS Plan.

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As noted earlier, all enrollments will go into effect on May 1, 2008. Once the new Plan begins, if consumers find themselves unable to access important medical providers or get their needs met under their new plan they should contact the PEBTF to see if they are eligible for a Special Election Period to change their Plan.

Consumers or advocates with questions about the changes to the PEBTF should contact the PEBTF at 1-800-522-7279. Calls can also be directed to the APPRISE Hotline at 1-800-783-7067 or to PHLP's Helpline at 1-800-274-3258.

CMS Orders Health Net to Stop Marketing and Enrollment for "Health Net Orange" Medicare Part D Plans

Last month, the Centers for Medicare & Medicaid Services (CMS) placed a marketing and enrollment freeze on Health Net, a Medicare Part D plan sponsor. The freeze applies to Health Net's "Health Net Orange" Prescription Drug Plans and is a result of the company's failure to process enrollment applications on time and for sending incorrect information to members about coverage changes in 2008.

Currently, there are two Health Net Orange PDPs offered in PA, **Health Net Orange Option 1** (a zero-premium plan for individuals with the full LIS) and **Health Net Value Orange Option 2**. Individuals who enrolled in the plan after January 16th (the date the freeze went into effect) will be given the opportunity to switch to another Medicare drug plan. The company is required to submit a corrective action plan to CMS.

We will keep you posted about any developments in future editions of the *Senior Health News*. Individuals who are having problems because of this freeze are encouraged to call our helpline at 1-800-274-3258 or 1-866-236-6310/TTY.

2008 Part D LIS Income Limits Announced

In the December 2007 *Senior Health News*, we updated readers about the 2008 resource limits for the Medicare Part D low-income subsidy (LIS) (also called "extra help with Medicare prescription drug costs"). In January, the 2008 income limits were announced. The guidelines to qualify for the low-income subsidy in 2008 are:

Full Subsidy

- ***Individual***: Income less than $1,170/month ($14,040/year); Resources less than $7,790.
- ***Married Couple***: Income less than $1,575/month ($18,900/year); Resources less than $12,440.

Partial Subsidy

- ***Individual***: Income less than $1,300/month ($15,600/year); Resources less than $11,990.
- ***Married Couple***: Income less than $1,750/month ($21,000/year); Resources less than $23,970.

Certain income disregards apply when determining eligibility for the LIS (i.e., $20 disregard for unearned income and significant disregards for earned income). Also, only certain resources are counted when determining eligibility (i.e., a home and car are not counted).

As a reminder, individuals can get applications at the local County Assistance Office or local Social Security Office. Online applications can be submitted at www.ssa.gov/prescriptionhelp.

There is no deadline for applying for this help! LIS applications that were filed in late 2007 that did not meet the 2007 income guidelines were held by SSA to be evaluated by the 2008 guidelines.

Statewide Listening Sessions Held on Aging Waiver Renewal

The State is proposing changes to the current Aging Waiver which is up for renewal this year. In January and February, the Office of Long Term Living held Listening Sessions around the State to outline some of its proposed changes to the waiver and to get input from the public and interested stakeholders about the proposed changes, how the waiver program is working and how the program can be improved.

The state plans to submit the waiver application to the Centers for Medicare & Medicaid Services (CMS) in April 2008 and hopes to get approval by the end of June, when the current waiver expires. According to the state, CMS is requiring much more detailed information in the current waiver application than it has in the past. CMS has raised concerns with State officials about the consistency of waiver eligibility determinations and service delivery across the state and is seeking assurance that freedom of choice is guaranteed for participants in the waiver program. In addition, CMS has indicated that the state must develop a comprehensive strategy for Quality Management of its waiver programs.

Some of the proposed changes are more fleshed out than others. The following proposed changes are of particular interest to consumers:

- Offering consumers a choice of whether they want care management services and whether they want these services through the local Area Agency on Aging;
- Changing how the Level of Care determination is done to give the state a greater role in the process;
- Proposing standardization of the definition of Personal Assistance Services (PAS) and delivery of PAS across the counties. Currently, there is no standard definition in the waiver and these services are not offered statewide.
- Including TeleCare services as an available service under the waiver and standardizing the delivery of these services across counties. TeleCare services use innovative technologies to promote and sustain independence and quality of life through services that include Health Status Measuring and Monitoring, Activity and Sensor Monitoring, Medication Monitory System, and Personal Emergency Response System (PERS).

Many individuals and groups testified or submitted written testimony about the need for improvements in establishing eligibility for the waiver or in accessing services through the waiver. Among other testifiers, the Intra-Governmental Council on Long Term Care revisited and reaffirmed the recommendations of its 2002 Barriers Elimination Workgroup Report. Individuals who were not able to attend the sessions or who still want to provide comments can do so via e-mail at RA-acwrenewal@state.pa.us or by sending their written comments to: Office of Long Term Living, Attention: Listening Sessions, P.O. Box 2675, Harrisburg, PA 17105.

Stay tuned to future editions of the *Senior Health News* for updates about any changes to the Aging Waiver!

Update on the Wellpoint Process for Dual Eligibles With No Medicare Part D Coverage

The Wellpoint process, also called the Point of Service (POS) facilitated enrollment process, is still available to dual eligible individuals who do not have Part D coverage and need medications. This process is important to individuals, especially to those who have been getting prescription coverage through Medical Assistance and become eligible for Medicare. Often times, individuals do not know that they can no longer get prescriptions through Medical Assistance once their Medicare coverage starts. In many cases, individuals find out about this when they go to the pharmacy to get a prescription refilled.

Individuals who have both Medicare and Medical Assistance can use the Wellpoint process for temporary coverage of their medications if they have no Part D coverage on file. In the past year, it has been clarified that this process can be used by both full benefit dual eligibles **and others who receive the Part D low-income subsidy (LIS).** This means that individuals who get any help from Medical Assistance (even if it is only payment of their Part B premium) can use the Wellpoint process to get prescriptions if they do not have active Part D coverage. Also, other low-income individuals who qualify for the low-income subsidy can use this process.

Individuals, their family members and or advocates can ask the pharmacy to take the following steps to use Wellpoint:

1) Confirm dual eligibility or LIS status (pharmacies can do this by checking for Medicaid card, asking to see an LIS award letter, or confirming eligibility through state system (like EVS)). In addition, the pharmacy also has to verify someone's Medicare eligibility and check the Medicare system for any active Part D plan enrollment.

2) Use the following information to bill Wellpoint for eligible individuals:
   Cardholder ID: Medicare HICN (on red, white, and blue card)
   Patient ID: Medicaid number (if applicable) from ACCESS card (either green or yellow)
   Bin: 610575
   PCN: CMSDUAL01

Starting in 2008, CMS has a new process to recover funds from Medicare beneficiaries who use the Wellpoint process but who are not eligible for Medicaid or LIS. In the past, pharmacies were held responsible for claims submitted on behalf of beneficiaries who later turn out to be ineligible for the Wellpoint process. Now, if someone uses this process who is not a dual eligible or eligible for the LIS, Wellpoint will send a notice (called an "Evidence of Eligibility" letter) asking for proof of Medicaid or LIS eligibility and telling the individual she has to reimburse Wellpoint for the amount billed through the Wellpoint process if no proof is submitted. If documentation is not provided in 60 days, Wellpoint will seek reimbursement from the beneficiary.

Individuals who are dual eligible or those who otherwise qualify for the LIS can contact our helpline at 1-800-274-3258 or 1-866-236-6310 (TTY) if they're having problems accessing medications under the Wellpoint process. For more information about the Wellpoint process, please see: http://www.cms.hhs.gov/States/065_Backgrounders.asp.

Medicare Advantage Open Enrollment Period Ends March 31, 2008

Medicare Advantage plans are Medicare managed care plans that cover all the services covered by Medicare Parts A and B and may cover some additional benefits that the Original Medicare program does not cover such as dental care, vision services/eyeglasses, and hearing exams/hearing aids. These plans may also include Part D coverage for prescription drugs. Plans that include prescription drug coverage are known as MA-PD plans (Medicare Advantage plans with Part D). Plans that just cover medical services and do not include any prescription drug coverage in their benefit package are called MA-only plans.

Any Medicare beneficiary has until March 31, 2008 to change their Medicare Advantage plan, enroll in a Medicare Advantage plan (if they currently have Original Medicare through the red, white, and blue card), or disenroll from a Medicare Advantage plan and go back to Original Medicare. This enrollment period is called the Medicare Advantage Open Enrollment Period and runs every year from January 1st through March 31st.

Medicare beneficiaries who do not currently have Part D cannot generally enroll in a MA-PD plan during this enrollment period. Likewise, Medicare beneficiaries who currently have Part D coverage cannot disenroll from Part D coverage during this enrollment period. The following types of changes are allowed during this enrollment period:

1. An individual in a Medicare Advantage Plan that includes prescription drug coverage (MAPD) can switch to a different MA-PD or go back to Original Medicare and join a stand-alone Prescription Drug Plan (PDP).

2. Individuals with Original Medicare and a PDP can join an MA-PD.

3. Individuals who are in a Medicare Advantage Only plan (no drug coverage) can only switch to another MA-only plan or go back to Original Medicare (they can't join a PDP).

4. Individuals with Original Medicare but no Part D drug coverage can only join an MA-only plan and not an MA-PD.

If you have questions about the Medicare Advantage Open Enrollment Period, please call Medicare at 1-800-633-4227 or 1-877-486-2048/TTY or APPRISE at 1-800-783-7067.

Medicare Part B Open Enrollment Ends March 31, 2008

The open enrollment period for Medicare Part B runs from January 1st until March 31st every year. If you did not enroll during your 7-month initial enrollment period (the 3 months before you turn 65, the month you turn 65, and the 3 months after you turn 65), you can still enroll in Part B. If you enroll before March 31, 2008, your Part B benefits will begin on July 1, 2008.

Remember! Those who have delayed enrollment may have to pay a penalty of 10% for every year they waited to enroll in Part B. This is in addition to the regular monthly premium (currently $96.40 for most beneficiaries; individuals with higher incomes pay a higher premium). Individuals with limited income and assets may qualify for programs to help with their Medicare cost-sharing (see page 9). Qualified individuals are not subject to the late penalty, can enroll in Medicare Part B outside of the Open Enrollment Period, and do not have to wait until July for their Medicare Part B coverage to start.

New Program Income Limits Announced for 2008

The 2008 federal poverty income guidelines are out! Below are the new guidelines for several programs. Because eligibility for many public benefits programs is based on the federal poverty level, this means that individuals who previously did not qualify for coverage may now qualify for state and federal programs using the new, higher income limits. Remember, not all income counts when determining eligibility. If you think you may be eligible for any of the programs, you can apply through your local county assistance office or online at www.compass.state.pa.us. You can also explore your eligibility through our online screening tool, the QUICKSCREEN, at www.phlp.org or by calling PHLP at 1-800-274-3258.

Program	2008 Monthly income (1 person)	2008 Monthly income (2 People)
Healthy Horizons (Full Medicaid and payment of Medicare Cost-Sharing) (100% FPL)	$867	$1167
QMB (Payment of Medicare Cost Sharing) (100% FPL)	$867	$1167
SLMB (Medicare Savings Program) (payment of Part B Premium) (120% FPL)	$1040	$1400
QI-1 (Payment of Part B Premium) (135% FPL)	$1170	$1575
Full Low-Income Subsidy for Medicare Prescription Drug Benefit (135% FPL)		
Partial Low Income Subsidy for Medicare Prescription Drug Benefit (150% FPL)	$1300	$1750
MAWD (Medical Assistance for Workers with Disabilities) (full Medicaid, payment of Medicare Cost-Sharing) (250% FPL)	$2167	$2917
HCBS Waiver (Home and Community Based Services Waiver Programs—full Medicaid, payment of Medicare Cost-Sharing, and supportive services to stay at home) (300% SSI Federal Benefit Rate)	$1911	

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.

Assisted Living Updates

1. Regulations Under Development

The Department of Public Welfare's Assisted Living Workgroup continues its work around the development of regulations for Assisted Living Facilities. The regulations to implement Act 56 of 2007 are expected to be drafted and published as proposed regulations in May 2008. There will then be a public comment period. The Department hopes to have final regulations published by the fall with implementation beginning in 2009.

2. Announcing the formation of The Pennsylvania Assisted Living Consumer Alliance!!!

In January 2008, the Pennsylvania Assisted Living Consumer Alliance was formed with the purpose of giving voice to consumers around the issue of assisted living. More information about the Alliance will be in the next SHN. In the meantime, consumers and advocates with inquiries should contact Alissa Halperin at ahalperin@phlp.org.

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