SENIOR HEALTH NEWS

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Governor's Proposed 2007-2008 Budget Focuses on Long-Term Living

On February 6, 2007, Governor Rendell announced his Proposed Budget for the next fiscal year – 2007-2008. The Budget includes an ambitious plan to reform the healthcare system in Pennsylvania, including the Cover All Pennsylvanians proposal. The proposed budget also includes plans to continue the Governor's efforts to rebalance the long term care system – calling for complete 50%-50% balance between nursing home and home and community based care to be achieved in the next 4 years.

A significant focus of the Governor's budget is long term living. The budget announcement includes the creation of the new Office of Long Term Living, which will be a joint Office under the Department s of Aging and Public Welfare to promote consistency in service delivery across the long term living services available in Pennsylvania. The following three principles will govern the administration's approach to reforming long term care:

1. Consumers will have more options to receive appropriate long term living services in cost effective settings that promote quality care
2. The long term living system should be balanced so that all appropriate options are accessible and available AND
3. State and federal funds should be prudently managed and individual assets must be optimized.

The administration established these as some of its priorities for 2007-2008:

1. That there be a 50%-50% split in nursing home and home and community based use by 2011-2012 and that progress be made in 2007-08 towards achieving this goal.
2. The passage of an Assisted Living bill.
3. That 2800 new individuals will be served in the PDA waiver.
4. The information about long term living services should be more easily available and that accessing those services should be possible through "one-stop" access points.
5. That the nursing home transition project (which helps nursing home residents return to home and community based living) should be strengthened.
6. That there be expansion of the domiciliary care program and other alternative residential settings.
7. Promotion of the Long Term Care Partnership to encourage the purchase of long term care insurance.
8. Develop a strategy to control nursing home expansion
9. Work to improve housing options
10. Institute a quality management system
11. Create a Long Term living services training institute

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Important Information for New Dual Eligibles: Requesting Retroactive Enrollment in Part D Plan

Many new dual eligibles face gaps in prescription drug coverage because they lose their drug coverage through Medical Assistance before they have enrolled in a Medicare Part D plan or before Medicare has auto-enrolled them into a Part D plan. Often times, they do not know that they no longer have coverage for prescription drugs until they go to the pharmacy for refills. These individuals can use the Wellpoint process to get medications at the pharmacy if they know to ask the pharmacy about this process and if the pharmacy knows to use that process. Some individuals end up paying for prescription drugs out of their pocket because they need the medication and do not know how else to get the medications. Others go without their medication until their Part D coverage starts (the first day of the month after they enroll in a plan).

In order to help dual eligibles who have this gap in prescription coverage, the Centers for Medicare & Medicaid Services (CMS) created a Special Election Period for full dual eligibles (those whose Medicaid coverage included more than coverage of the Part B premium) who enroll in a Part D plan before Medicare auto-enrolls them. This Special Election Period allows qualified individuals to request that their Part D plan back-date the start date of coverage to the first day of the month when they became a dual eligible and therefore had no drug coverage.

Here's an example of when this Special Election Period may help a dual eligible individual: A person who has been receiving Medical Assistance becomes eligible for Medicare on March 1, 2007. She goes to the pharmacy on March 15, 2007 to get a prescription refill and finds that she does not have any prescription drug coverage. She can enroll in a Part D plan, but the start date would be April 1, 2007. She really needs the medication and pays out of pocket for the medication. Under this Special Election Period, she can ask her Part D plan to make the enrollment retroactive to March 1, 2007 in order to have the pharmacy bill the Part D plan and reimburse the money she paid out of pocket for the medications.

If you have any questions about these Special Election Periods, or if you are having problems using these Special Election Periods, please call the PA Health Law Project helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

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12. Assure a clear, equitable and efficient eligibility process and
13. Improve service delivery systems management

Other than its role in the establishment of the Office of Long Term Living, the Department of Aging announced no new initiatives. In its briefings, the Department spoke primarily about the PACE Plus Medicare expansion that began in the summer of 2006 and how this has enabled the PACE program to enroll up to 120,000 more older Pennsylvanians.

For more information about the state budget and the Governor's Health Care Reform Plan (called "Rx for PA"), attend one of our free budget briefings in March. See the enclosed flier for more details.

Medicare Advantage Open Enrollment Period Ends March 31, 2007

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 aides. These plans may also include Part D coverage for prescription drugs. Plans that do 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, 2007 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 from January 1, 2007 through March 31, 2007.

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 do 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:

- An individual in a Medicare Advantage Plan that includes prescription drug coverage (MA-PD) can switch to a different MA-PD or go back to Original Medicare and join a stand-alone Prescription Drug Plan (PDP).
- Individuals with Original Medicare and a PDP can join an MA-PD.
- 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).
- 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 Periods, please call Medicare at 1-800-633-4227 or APPRISE at 1-800-783-7067

Do you live in a personal care home or working with someone who lives in a personal care home? Are you concerned about the care they are receiving? Are you wondering if the home is following the new regulations? Please call the Pennsylvania Health Law Project helpline at 1-800-274-3258/ 1-866-236-6310 TTY to get your questions answered.

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

Announcing:

The Pennsylvania Health Law Project's

6th Annual State and Federal Budget Briefing

(Including Summary of the Governor's RX for PA and Cover All Pennsylvanians Plan)

3 Dates/3 Locations

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Visit us online at www.phlp.org !!

Briefing Dates and Locations

3/9/07— From 10am—12pm at 1414 N. Cameron Street—1st Floor Conf Room, Harrisburg, PA

3/14/07— From 9:30-11:30 at Philadelphia Bar Association, 1101 Market Street—11th Floor Philadelphia, PA — *Note: Arrive early and Bring Photo ID to get through Security*

3/16/07— From 9:00-11:00 at City County Bldg, 411 Grant Street, Academy Room, 9th floor, Room 920– Pittsburgh, PA

Denied a medication through Medicare Part D? Appeal!

If a consumer is prescribed a new medication or a dosage that isn't covered by her Medicare Prescription Drug Plan, she can request an exception to the Plan's formulary and appeal if the request is denied. The first step is for the consumer or the prescribing doctor to request an exception to the Plan's formulary. The prescribing doctor must provide the Plan information (orally or in writing depending on the Plan's process) that the requested medication/dosage is "medically necessary" to treat the consumer's condition because:

- the other drugs listed on the formulary to treat the condition would not be as effective as the requested drug and/or would have adverse effects on the consumer, *or*
- the formulary drugs required to be used under the Plan's step therapy regime have been, or are likely to be, ineffective for the consumer or are likely to cause adverse side effects, *or*
- the formulary dosage has been, or is likely to be ineffective, or it will have adverse effects on the drug's effectiveness or on the patient's compliance

The Part D Plan has 72 hours after receiving the prescribing doctor's information to decide on the exception request. The request must be granted if the Plan determines the drug is medically necessary for the consumer, consistent with the prescribing doctor's statement. If the Plan approves the request for a formulary exception, it decides what the tiering/co-pay level will be for the drug. With few exceptions, the approval of coverage is good for the remainder of the calendar year. **Please note:** if the medical evidence shows that the standard timeframe for making a decision (72 hours) may seriously jeopardize the consumer's life, health or ability to regain maximum function, the Plan must issue an expedited decision in 24 hours!

If the consumer disagrees with their Part D Plan's decision, or if their Plan fails to decide on their request in a timely manner, the consumer can appeal further. The Part D Plan must provide information on the next steps in the appeal process.

Can someone else act on behalf of a consumer to request a program exception or appeal?

Yes. Medicare Part D authorizes others to act on a consumer's behalf. They include:

- the prescribing physician;
- a person appointed by the consumer to act on his behalf;
- persons authorized under state law to act on a consumer's behalf which includes
  - ◊ those given authority under a Guardianship or a Power of Attorney

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Dual Eligibles encounter problems getting diabetic supplies

The Pennsylvania Health Law Project has heard from many dual eligibles who need diabetic supplies and but have been asked for large copays for the supplies. Diabetic supplies such as needles and test strips are covered by Medicare Part B. The Part B copayment and deductible is covered by Medical Assistance for dual eligibles. However, some dual eligibles were being charged a copayment or were told that the items were not covered. PHLP has found out that the Department of Public Welfare had these items coded as Medicare Part D items. The Department has been working through these problems on a case by case basis with pharmacists, when pharmacists call the Fee-for-Service pharmacy helpline, 1-800-558-4477.

The coding problem should be fixed by the beginning of March. Dual eligibles who paid a large copayment or deductible for their diabetic supplies can get reimbursed by their pharmacy now, if their pharmacy bills Medicare and Medical Assistance.

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- those designated a "substitute health care decision makers" for persons with mental retardation.

Can the consumer request a formulary exception or appeal the Part D Plan's denial of <u>any</u> drug?

The exception and appeals processes can be used for most prescription drug denials. However, they are not available if the consumer is requesting coverage for drugs that are not Part D drugs. These include:

- medications already covered under Medicare Part A or Part B
- benzodiazepines, barbituates or over-the-counter drugs (unless the consumer is enrolled in an Enhanced Alternative Part D Plan that offers coverage for these non Part D drugs)
- drugs or classes of drugs which can be excluded from coverage or otherwise restricted under Medicaid.

Shingle Vaccine for People over 60– but how to get it?

Doctors may now be recommending a new vaccine to people over 60, to prevent a painful condition known as shingles. Consumers need to be aware that this vaccine may not be covered by insurance, or may have a high co-pay and that this will vary for each person based on their health insurance.

Shingles, the common name for the medical condition officially known as Herpes Zoster, is a very painful rash that can develop in any adult who ever had chicken pox as a child. Even after the rash disappears, the pain can remain forever in the nerves. So it should be welcome news that there is a new vaccine (*Zostavax* ®) that was approved by the Food and Drug Administration in May 2006 to prevent shingles. The Centers for Disease Control have made preliminary recommendations that all persons over 60 receive the vaccine. There is only one problem – the vaccine is expensive, and getting it paid for is not simple.

According to the Medicare Modernization Act of 2003, all new vaccines will be reimbursed under Medicare Part D. Older vaccines usually given in the Medicare population, such as flu shots or pneumonia shots, are paid for by Part B. *Zostavax* is the first new vaccine to be covered under Part D. And that leaves a few unanswered questions.

Some, but not all Medicare Part D plans cover the shingles vaccine. In Pennsylvania, 128 different Part D plans are covering *Zostavax* according to www.Medicare.gov, most in tiers that involve high cost sharing. However, if the doctor's office buys the vaccine and then gives the shot, the doctor cannot bill Medicare Part D – only pharmacies can do that. If the doctor buys the drug, and charges the consumer for it, the doctor is an "out-of-network" provider under Medicare Part D. That means the doctor may charge a consumer for the vaccine (about $150) and require the consumer to file paperwork with his Medicare Part D plan to be reimbursed. At the present time, PHLP is not aware of whether consumers have tried this, or what has been the outcome.

Doctors also usually charge a fee to give a vaccine. For 2007 only, providers can bill Medicare Part B for the cost of giving the shingles vaccine. However, this was permitted by a little known portion of a Tax Relief Act passed by Congress in December 2006, and many physician offices may not yet be aware of it. Doctors who participate in Medicare cannot bill the consumer for the administration of the vaccine.

Are there any other choices? The doctor could write a prescription for the vaccine, and the consumer could take it to a retail pharmacy and return with it to the office to have it administered. This is somewhat impractical, because the vaccine is stored frozen and must be given within 30 minutes of defrosting.

Because pharmacies are in-network providers under Medicare D, and pharmacists can be licensed in Pennsylvania to administer vaccines, it is theoretically possible that some pharmacists could administer the vaccine. However the Pennsylvania Pharmacists Association confirmed that as of February 2007, only 168 pharmacists across the state are currently licensed to administer

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vaccines. In addition, many pharmacies participate in Part D but not in Part B, and so they would not be able to bill Part B.

What should be done now? If you are a consumer and a physician recommends the Zoster/shingles vaccine, ask first if they are sure your Medicare Part D plan, or other insurance plan if you are not on Medicare, will cover it. If you will need to submit out-of-network paperwork for reimbursement, ask if they have the paperwork and will help you fill it out.

Also check to see under what tier your plan covers the vaccine, and how high your co-pay might be. In some plans, high tier drugs can have co-pays of $30-$50, or 25% of the cost of the drug. If you are in the "doughnut hole" or have not met a deductible, you could be responsible for the entire amount.

Because the shingles vaccine is new, and because this is the first time Medicare Part D is paying for a vaccine, the chance of contradictory or inaccurate information is high. The answers must come not from Medicare, but from each different insurance company, because that is how Medicare Part D is set up. PHLP was not able to get definitive answers to many of our questions as we prepared this article. Web sites and printed materials may not be up to date. Health care providers, and insurance companies, may accidentally give or receive inaccurate information.

If you want the shingles vaccine, or if your doctor recommends it, take some time to receive accurate written information not just about the medical effects of the vaccine, but also about your financial responsibilities! Get the name of anyone you speak with at your Part D plan. The Centers for Medicaid and Medicare Services, and the insurers, are aware that this is currently awkward for patients and physicians, and are trying to work on possible solutions. Senior Health News will keep you updated.

2007 Pennsylvania Aging and Behavioral Health Forums Announced!

A one-day program for individuals working with older adults who are at risk for developing behavioral health problems, including social workers, housing coordinators, personal care and assisted living staff, nursing home and home health care providers. The forum will emphasize a multidisciplinary approach to providing services to older adults and the need for cross system collaboration. County's offering Mental Health and Aging Best Practice programs will be highlighted. Information on a variety of services available to older adults will be discussed

For more information/ to sign up, contact Joann Roesner @ 215 831-7804 or jroesner@drexelmed.edu

Dates/ Sites

April 9th, 2007- Drexel University College of Medicine Queen Lane Medical Campus 2900 Queen Ln Philadelphia, PA 1912	May 2, 2007- Nittany Lion Inn 200 West Park Ln State College, PA 16803

Getting cut off the 60+ Aging Waiver?

The Pennsylvania Health Law Project has seen a **big** increase in the number of seniors that are being cut off from their 60+ Aging Waiver **even though** they still need the waiver services.

Seniors who have been on the 60+ Waiver for several years have been calling PHLP to report that they are suddenly being told they don't need the waiver. Some are offered "Options" services instead. The reason appears to be a policy change at the state's Department of Aging, but no change has been announced publicly. PHLP has been assisting these individuals in appeals and helping them to keep their waiver services.

Please contact the Pennsylvania Health Law Project at (800)274-3258 or (866)236-6310 TTY if this has happened to you or to any of the seniors with whom you work. PHLP wants to hear about this and wants to help consumers remain in the community with the supports they need.

Pennsylvania Health Law Project
437 Chestnut St., Suite 900
Philadelphia, PA 19106