SENIOR HEALTH NEWS

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Getting Healthcare for Veterans

The Veterans Administration provides primary care, specialized care and other medical services to eligible Veterans primarily through Veterans Administration Healthcare Facilities. Once enrolled, a veteran receives care free of premiums and with limited copayments (and, for some, no copayments).

While Veterans Healthcare is a very useful option to explore for potentially eligible seniors, it is important to note that Veterans care is not health insurance. It is healthcare services. It is also important to note that, with the exception of emergency care, a veteran cannot simply show up at a Veterans Administration Healthcare site and request services. He/she must apply for and enroll in the healthcare program in order to be able to receive care or services. When enrolled, veterans receive all health care and pharmaceutical services from any of the 50 VA facilities in Pennsylvania, with the exception of emergency care requiring emergency room visits, which the VA will pay for at other hospitals if the individual does not have other means of doing so.

Who is Eligible for healthcare?

To be eligible for healthcare, one must have served on active military service in the Army, Navy, Air Force, or Coast Guard (or Merchant Marines, during World War II) and must fall into one of the priority groups currently receiving services. Applicants must have also been discharged under other than dishonorable conditions. Those who were in the Reserves or National Guard and were called to active duty under executive orders may also qualify for benefits.

Eligibility is not limited to those with combat related injuries, nor is care limited to addressing combat or service related health conditions. Also, other groups who have provided service to the US military and military vets from allied countries who participated in World War I and World War II are also eligible for care.

Within those eligible groups, care is given to people based on priority groups. Veterans are placed in certain priority groups based on criteria such as income, length and level of military service, and medical need. At the top are people who have been POW's, people wounded in combat, and people with disabilities that have been determined to be caused during their military service. At the moment, new level eight (lowest priority) veterans are not being accepted at all for treatment, although previously enrolled level eight veterans are still being seen. Priority group level eight veterans are those with the highest incomes and least amount of medical need.

What does care cost?

There are no monthly premiums for partici-

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pating in the Veterans Healthcare system. For most veterans, there are some co-payments for services received. Some veterans do not have to pay co-payments if their income is low enough. But all veterans with disabilities that resulted from their time in the service receive care for that disability for free. If the disability is rated at 50% or higher, s/he gets the rest of his care without co-pays also. Veterans with service connected injuries and disabilities get free care, for those conditions, even without co-payments. Also if a veterans has private insurance, the private insurance is never billed for treatment of service connected disabilities.

What healthcare services are provided?

All enrolled veterans have access to the Medical Benefits Package. There are some other specialized services that are offered to only some veterans. The Medical Benefits Package includes preventive care services such as immunizations and screening tests, outpatient care such as surgery and emergency care at VA facilities, inpatient care, and medications such as prescription medicines. The special benefits include programs for special war related illnesses, dental care, and prosthetic limbs, that not everyone qualifies for or needs. The VA also has the authority to pay for emergency care in non-VA facilities for veterans enrolled in the VA health care system, if the patient has no other source of payment.

If a veteran does not have means of transportation and lacks the money to get to a facility, the VA pays or reimburses up to $18 monthly for transportation, but only if the veteran is 30% or more, service-connected disabled. Also, the Disabled American Veterans, a nationwide non-profit organization, will provide free, door to door transportation to VA facilities to disabled veterans who cannot otherwise get there.

Prescription drug coverage is available to all priority groups. Priority group one gets all of their care for free, even their prescription drugs. For priority groups two through six, there is an $8 co-pay for a thirty day supply of prescription drugs, a $960 cap on out of pocket payments for those drugs.

Interaction with Medicare Part D

The VA prescription drug coverage is considered “creditable coverage,” which means that veterans may choose to enroll in Medicare Part D if they choose and will not have to pay any fee for late enrollment. In the case that a veteran is enrolled in both programs, they get to choose which plan pays for which drugs. However, VA prescriptions must be written by a VA practitioner, and filled in a VA pharmacy.

Where are VA Health Care Facilities?

The VA has health care facilities all over the country. At http://www1.va.gov/directory/guide/home.asp, you can search by state to find which are closest to you. Also if you are away from home you can find facilities close to where you are by calling 1-877-222-8387.

How does one apply/enroll in VA Health Care?

Applications can also be found at the VA’s website www.va.gov or by calling 877-222-VETS (8387) toll free.

Next Edition: Learn about the Department of Defense’s TRICARE FOR LIFE program.

Waiver Eligibility Issue Continues

Pennsylvania has 10 Home and Community Waiver programs providing supportive services to consumers with disabilities in the community instead of in an institution. To be eligible for receiving services in the community (at home) instead of the institution, however, the person wanting services at home must actually have need for the same kinds of services provided in the institution. This is called clinical eligibility. Thus, for a person trying to get into the Aging Waiver, they must be found to be clinically eligible or to have need for the same kinds of services provided in a nursing home. This is often referred to as nursing facility clinical eligibility.

Several other home and community based services waiver programs also require a person to be nursing facility clinically eligible. These are the LIFE program, the Attendant Care Waiver, the HIV/AIDS waiver, and the Elwyn Waiver. Federal Medicaid law mandates that nursing facilities provide Medicaid covered care to individuals who need either skilled nursing care or intermediate level of care.

As mentioned in our last edition, there has been a disturbing change to the nursing facility clinical eligibility (NFCE) standard that has functioned to require consumers to have skilled care needs in order to remain eligible for the Aging waiver. It is critically important that advocates and consumers understand and remember that applicants for the Aging Waiver, the LIFE program, the Attendant Care Waiver, the HIV/AIDS Waiver, or the Elwyn Waiver do not need to have skilled needs and do not need to have a skilled level of care in order to be served under the Waiver. Numerous consumers across the state, over the past 18 months, may have been wrongly terminated from waiver services they already had been receiving or denied waiver services for which they had newly applied. We now understand that upwards of 500 consumers may have been wrongfully terminated from the Aging waiver alone in the past 18 months.

The state has agreed to review the case files for all consumers who were terminated between January 2006 and March 2007 and reinstate those consumers who were erroneously terminated due to being nursing facility ineligible after previously being nursing facility clinically eligible. The state is considering review of all those who were denied access to a waiver for being nursing facility ineligible. And, the state is still considering whether to withdraw the unlawful standard and replace it with a lawful and more clear standard.

The Pennsylvania Health Law Project wants to make sure that all consumers who were t**erminated** from a waiver for being nursing facility ineligible (after previously being nursing facility clinically eligible) get reinstated as they should be. We would also like to hear from any consumers who have been **denied** eligibility for and thus admission into a HCBS Waiver on the grounds that they are “Nursing Facility Ineligible”. While PHLP is always available to assist terminated and denied consumers in appealing their terminations or denials, in this instance, we would like to assist in expediting the state’s case review. Any consumer who was terminated from a HCBS Waiver for no longer being nursing facility clinically eligible or who has been denied eligibility/admission into a waiver for not being nursing facility clinically eligible should call our toll-free helpline at (800)274-3258 or (866) 236-6310 TTY.

Medicare Private Fee For Service Plans Prohibited from Marketing Activities

Last edition, we reported on Medicare Private Fee For Service plans (PFFS). While these plans are Medicare Advantage plans, and thus delivery of Medicare coverage is through a private insurance company under contract with Medicare, these plans differ from the most common Medicare Advantage plans—HMOs. PFFS plans provide coverage in the same way that traditional Medicare does, through a fee-for-service system, only under a private plan. That means that consumers enrolled in a PFFS are not limited by a network as might be the case in another Medicare Advantage plan, **however**, the plan will only pay providers who accept the plan's conditions and payments. Beneficiaries can be hit with bills from their providers or could lose providers who decide not to accept the terms of the plan.

As we discussed last edition, marketing of private Fee-For-Services has been under tremendous scrutiny and beneficiaries have complained widely of misinformation and other questionable marketing practices. Due to an overwhelming number of complaints and concerns with Medicare Advantage Fee-For-Service Plans marketing, seven of the largest health insurers offering private-fee-for-service (PFFS) Medicare Advantage plans have agreed to suspend their marketing of the plans, CMS officials announced on Friday June 15, 2007. Included in the voluntary suspension are United Healthcare, Humana, Wellcare, Universal American Financial Corporation (Pyramid), Coventry, Sterling, and Blue Cross/Blue Shield of Tennessee. These insurers collectively provide insurance for about 90% of all MA private fee-for-service plan beneficiaries.

The suspension for a plan will be lifted only "when CMS certifies that the plan has the systems and management controls in place to meet all of the conditions specified in the 2008 Call Letter and the May 25, 2007 guidance issued by CMS". (CMS Press Release, 6/15). These conditions are inclusive of informing beneficiaries that the plans do not guarantee a physician will accept them as a patient; requiring sales agents to pass written examinations testing knowledge of MA plan details; calling prospective beneficiaries to ensure they understand fully how their MA plan will work; and working with physicians and other providers to increase understanding of how the plans function. (CMS Press Release, 6/15). CMS will review the plans as soon as plans indicate they are ready, the suspension will not be lifted until CMS review and approval has taken place. Additionally, CMS has committed to actively monitoring performance once marketing resumes. Any violations of the requirements set forth in CMS guidance will supposedly be remedied immediately.

Consumers who have experienced something such as being provided misinformation from Private Fee For Service Plans, being wrongfully enrolled into a plan or being erroneously billed can complain to CMS, though the regional office for Pennsylvania at 215-861-4140 or by emailing PartDComplaints_RO3@cms.hhs.gov. Consumers can also complain to the Pennsylvania Department of Insurance about individual agents by calling toll-free 1-877-881-6388**.**

Assisted Living Legislation Moving Quickly in Pennsylvania's Legislature

For years, Pennsylvania has considered the need to develop separate licensure and regulation of assisted living residences. In numerous prior legislative sessions, there have been bills proposing to license and regulate assisted living. This year there have been four Assisted Living Bills introduced in the Pennsylvania Legislature. House Bill 375, introduced by Representative Watson, HB 1213, introduced by Representative McIlvaine Smith, HB 1583 introduced by Representative Mundy, and SB 704 introduced by Senator Vance.

It appears that the House and Senate Aging Committees are negotiating language for swift passage of assisted living, possibly even for passage by early July. SB 704 is expected to be the vehicle for assisted living licensure with additional amendments to be forthcoming from Representative Mundy and the Rendell Administration. It is striking how swiftly the houses seem intent to move bills that were either introduced or amended just last week. Many consumer groups are concerned about the haste.

Most consumer groups feel that assisted living must contain several key elements. The Consumer Subcommittee of the Medical Assistance Advisory Committee, for example, urged the Administration to ensure that the Mundy bill (which the Administration was drafting for Representative Mundy) contained at least the following critical elements:

1. A separate controlled public funding stream must be dedicated and existing HCBS waiver programs must be protected.
2. There must be sufficient, accessible, private living space and bedroom for all consumers, regardless of income and Access to assisted living.
3. Privacy, dignity, self-direction, choice, independence, and autonomy in residency and services, including choice of services provider must be ensured.
4. A complete list of unwaivable residents' rights must be articulated.
5. A consumer's individual needs and preferences must be evaluated and frank discussion and service planning must take place as to how those needs and preferences will be met prior to a contract for residency in an Assisted Living Facility.
6. All requirements and expectations must be fully, fairly, and understandably disclosed in writing prior to a contract for residency in an Assisted Living Facility.
7. All facilities must meet the most current standards for safe and accessible physical site design.
8. Residents must not be forced expressly or by threat of discharge to sign negotiated risk agreements.
9. An affirmative obligation to reasonably accommodate needs and preferences must be included.
10. Licensure and enforcement tools must be articulated in statute and these must greatly exceed the inadequate array of tools currently operating in the personal care home enforcement activities.
11. Any bill must state clear minimum standards for staff and administrator qualifications and initial training requirements that must be satisfied with demonstrated competency prior to independent work with residents as well as continuing education requirements.

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Many other groups representing seniors and persons with disabilities raised similar and numerous other concerns. At the time of this writing, SB 704 does not include all these elements. It is unclear what will be included in the amendments that are being prepared. Yet, there continues to be a push to pass SB 704 within the week.

Our next edition will include an update on Assisted Living.

Community Education Corner

Please call us at 800-274-3258 or 866-236-6310 TTY, if you would like to have the Pennsylvania Health Law Project provide you or your group with training on:

1) Medicare eligibility or coverage
2) Medicaid eligibility or coverage
3) Publicly funded programs to help seniors save money on prescriptions, healthcare costs, and more
4) Long term care options—including home and community based services/alternatives to nursing homes
5) Healthcare for immigrants
6) Health coverage options for the uninsured or
7) Other Important Healthcare Topics

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2. No monthly premiums for your Medicare Drug Coverage (Part D).
3. No premiums, deductibles, or copayments for Your Medicare Healthcare (Parts A and B).
4. Additional healthcare services at little or no cost through the Pennsylvania Medicaid program.

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Pennsylvania Health Law Project's
toll-free helpline at
(800)274-3258 or (866)236-6310 TTY
for more information and free confidential assistance on saving money and getting better healthcare.
We can also advise you on how to use your Medicare Drug coverage.

Visit us online at www.phlp.org!

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New Notices from DPW to "NEW" Dual Eligibles Explain How Medical Assistance Coverage Will Change When Medicare Starts

Last month, the Department of Public Welfare (DPW) began sending notices to individuals on Medical Assistance (MA) who are becoming eligible for Medicare in the upcoming months. These notices explain how an individual's Medical Assistance coverage will change when she becomes eligible for Medicare. The primary change these consumers will experience is the shift in their prescription drug coverage from Medical Assistance to Medicare Part D. These individuals will need to join a Medicare Part D plan to get ongoing prescription drug coverage because Medical Assistance will no longer cover most prescription drugs. Another change that individuals with Medical Assistance may experience when they become eligible for Medicare is disenrollment from a Medical Assistance HMO and the transition back to MA fee-for-service (i.e., ACCESS) for their physical health coverage. The notices also provide information about certain types of prescription drugs that the ACCESS card will continue to cover for qualified recipients (i.e., benzodiazepines, barbiturates, and some over-the-counter medication).

DPW began mailing notices to individuals in the MA fee-for-service system in May. Notices to individuals in MA HMOs will be sent notices starting in July. Both notices will be available in Spanish. Notices will be sent on a monthly basis to individuals for whom DPW has received information from the Centers for Medicare & Medicaid Services (CMS) that their Medicare benefits will begin in the upcoming months.

PHLP staff along with other consumer advocates have been pushing the Department to send notices to individuals on MA who become eligible for Medicare to explain the changes to their prescription coverage and/or their disenrollment from their Medicaid HMO. We are happy to learn that notices are starting to go out to affected individuals.

If you have questions about these notices or want more information about how Medical Assistance coverage changes when someone becomes eligible for Medicare, please contact the PHLP Helpline at 1-800-274-3258 or 1-866-236-6310 (TTY). You can also contact the Medical Assistance Call Center at 1-866-542-3015 or 1-877-202-3021 (TTY).

Get Precise Details Specific to Your Medicare Coverage at www.MyMedicare.Gov

Medicare consumers can get important information about their Medicare accounts through the internet. Sign up at mymedicare.gov to get information about Medicare claims that have been paid, see what Medicare plans you are enrolled in and copies of Medicare forms that you need.

Dental Coverage for Seniors Through Medicaid Fee For Service/ACCESS

Many dual eligibles have been having trouble finding dental providers. Here is some information to review what dental benefits are available to seniors who have Medicare and Medicaid, how to find providers for duals, and what to do if a dual is still having trouble accessing dental care.

Dual eligibles have comprehensive dental coverage through Medical Assistance. This includes services such as: Diagnostic (exam & x-rays), Preventive (prophys), Restorations (amalgam and composite restorations), Extractions, Other types of oral surgery, Complete and partial dentures (limited to every five years), and Root canals and Crowns. Note: Many of these services must be prior authorized or have limits on how many in a period of time.

In order to receive coverage for dental services, a dual eligible must see a dentist who accepts Medical Assistance. This can be difficult as there is a dental shortage in Pennsylvania, especially for Medical Assistance consumers. Some dentists are in a HealthChoices plan but will not accept patients who have Medical Assistance Fee-for-Service. Technically, those dentists are enrolled with Medical Assistance Fee-for-Service (Access) but may not understand that or may not want to deal with Access.

Medicare generally does not cover dental services though some Medicare Advantage plans have a dental benefit. If the Medicare Advantage plan has a dental benefit, the dual eligible must first use the Medicare Advantage plan benefits before accessing Medical Assistance coverage. Ideally, she would find a dentist who accepts both the Medicare Advantage plan and the Medical Assistance plan though we have heard from clients that finding a dentist who takes both is difficult and time consuming. If the dual eligible cannot find a dentist who takes both plans, then she can use her Medicare Advantage plan benefit first and then may have to transfer to a different dentist who will accept the Access card.

If a dual eligible needs a dentist and does not already have one, she can find a dentist through the Medical Assistance dental hotline- 1-800-509-0987. She can get the names of up to 6 dentists in her area through that line. Please note that this hotline is not limited to dual eligibles- all Medical Assistance beneficiaries in Fee-for-Service can use the hotline to find a dentist. Medical Assistance consumers in HealthChoices or Access Plus should call their plan to find a dentist.

If you have had trouble finding dentists who take Access through this hotline, please call our helpline at 1-800-274-3258/ 1-866-236-6310 TTY.

The state has made efforts to increase the number of dentists who accept Medical Assistance Fee-for-Service but the results are not yet in.

Next Edition: We'll review the rules around access to Vision and Hearing services.

Other Dual Eligibles Access Care and Services Problems through Medicaid Fee-For-Service/ACCESS Program

We continue to hear of dual eligibles who are struggling to access health care through the ACCESS Program. Consumers are finding themselves without healthcare providers for their Medicaid services and without a clue where to find a healthcare provider for their Medicaid services. By way of review, we want to remind you of the following rules:

1) Dual eligibles can see their Medicare Providers for Medicare covered services.
   a. Dual eligibles are not required to see providers that participate in/accept ACESS for Medicare covered services.
   b. Any Medicare provider can balance bill Medicaid ACCESS even if the provider is not a Medicaid ACCESS participating provider.

2) Dual Eligibles are not responsible for amounts left unpaid by Medicare.
   a. Medicare co-payments and deductibles are not the responsibility of the dual eligible.
   b. If one has Medicare and Medicaid, she can see her Medicare doctor for services covered by Medicare and not be billed for balances unpaid by Medicare. Those balances must be billed to the Medicaid Access program (which can be done even if the doctor is not a Medicaid enrolled provider) or not billed at all.

3) Dual Eligibles can continue to get Over the Counter, Benzodiazepines, and barbiturates through the Medicaid program using their ACCESS cards. Pharmacies should bill Medicaid instead of Medicare Part D plans for these medications.

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