Health Law PA News

Newsletters of the Pennsylvania Health Law Project
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MIPPA Changes to LIS and MSP Start 1/1/2010

Starting January 1, 2010, more low-income Medicare recipients should be able to qualify for important programs such as the Medicare Part D Low-Income Subsidy (also known as "Extra Help") and the Medicare Savings Programs (also known as the "Medicare Buy-In" and hereinafter referred to as "MSP") as a result of changes made by the Medicare Improvements for Patients & Providers Act of 2008 ("MIPPA").

Changes In The Low –Income Subsidy

The Low-Income Subsidy Program (LIS) was created to help low-income Medicare beneficiaries pay for the costs of the Medicare Part D Prescription Drug Program. Individuals who qualify for the LIS: have no donut hole (coverage gap where the person must pay the full price of their drugs), can enroll or change Part D plans throughout the year, and are not subject to the Part D late-enrollment penalty. To qualify for an LIS in 2009, a single person must have ***countable*** income less than $1,354/month (150% FPL) and ***countable*** assets less than $11,010; a married couple living together must have ***countable*** income less than $1,821/month and ***countable*** assets less than $22,010. MIPPA makes changes in how income and assets are counted for the LIS Program starting January 1, 2010. The income figures to qualify for an LIS may increase in 2010 (the Federal Poverty Levels are updated every year, usually in February) but the asset limit for the LIS will remain the same in 2010.

Counting Assets Under LIS

Currently, life insurance ***does*** count as an asset when determining LIS eligibility. If the applicant (or their spouse) own life insurance policies with a total face value greater than $1500, they must report the cash surrender value of the policies on the LIS application. Social Security then counts the entire cash surrender value of the policies as an asset. However, ***effective January 1, 2010 life insurance will no longer count*** as an asset at all when determining LIS eligibility!

Counting Income Under LIS

Currently, if the applicant receives any "in-kind support and maintenance" it is counted as income for the LIS. "In-kind support and maintenance" includes help someone receives on a regular basis to pay for food, housing, utilities, and/or property taxes. It does not include help

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received from a government program (for example, LIHEAP, foodstamps) or from a social service agency (Meals on Wheels, foodbanks, etc). ***Beginning January 1, 2010, in-kind support and maintenance will no longer count as income when determining eligibility for the LIS!***

Changes in the Medicare Savings Programs

The MSPs are programs in which the Pennsylvania Medical Assistance system pays the Medicare Part B premium for low-income Medicare beneficiaries who qualify. To qualify for an MSP, individuals must have income less than 135% of the federal poverty level (currently, $1,219 for a household of 1; $1,640 for a married couple living together) and have limited assets. MIPPA changes the way assets are counted for the MSP programs.

Increasing the MSP Asset Limit

In 2009, to be eligible for any of the MSPs an applicant must meet the current asset limits which are $4,000 for a single person and $6,000 for a married couple. ***Effective January 1, 2010 the asset limit for the MSP increases to be the same limit as the full Low Income Subsidy (LIS) which is currently $6,600 for a single person and $9,910 for a married couple. According to a recent announcement, the LIS asset limits will not change in 2010.***

Keep in mind, however, that even though the MSP asset limit in 2010 will be the same as the asset limit for a full LIS, the MSP program differs from the LIS regarding how assets are counted and what assets are counted when determining who qualifies for an MSP. Specifically, there are two key differences:

- When counting assets, the LIS program automatically disregards $1500 for an LIS applicant and $1500 for their spouse unless they indicate on the application that they do not plan on using any of their assets to pay for funeral and/or burial expenses. The MSP does not allow this disregard. The only funeral/burial assets the MSP does not count are burial plots and funds set aside in an irrevocable prepaid burial account.
- Unlike LIS in 2010, the MSP program will continue to count life insurance as an asset. If the total face value of the applicant's life insurance policies is greater than $1500, then the MSP program will count any cash surrender value over and above $1,000 as an asset.

Using LIS Data to Facilitate Enrollment into the Medicare Savings Programs

MIPPA also creates a new process of data-sharing between Social Security and the state Department of Public Welfare (DPW) to help facilitate enrollment into the Medicare Savings Programs (MSPs). Currently, being found eligible for the LIS does not assist the individual with being found eligible for an MSP. Anyone who applies for an LIS and is approved must contact DPW on their own and complete an MSP application to be considered for that program. This will change next year.

Effective January 1, 2010, Social Security will begin to share data with the Department of Public Welfare to assist consumers who may be eligible for the Medicare Savings Programs. Once Social Security acts on an LIS application and determines LIS eligibility, they will send all the information they have on the applicant to DPW. DPW will then forward the information to the appropriate County Assistance Office (CAO) depending on where the applicant lives. The CAO will act on the information as though it were an application for the MSP. The CAO will send out a Data Collection Sheet to the consumer seeking any addition information/verifications needed beyond the data sent by Social Security to determine MSP eligibility. If the consumer responds in a timely manner and sends in the requested information, the CAO will go on to determine whether or not the person qualifies for an MSP. If the consumer does not respond to the CAO's request within the time period provided, the MSP application will be denied. Consumers can appeal this denial and seek a Fair Hearing just as with any other DPW decision.

Please note: the description of the DPW process provided in the paragraph above is based on the most recent information given to PHLP by DPW staff of how the state was planning to implement the changes required by MIPPA. If we learn of changes to this process, we will update our readers as quickly as we can.

PHLP Releases Uninsured Pennsylvanians- A Report of Personal Stories Illustrating the Importance of Health Care Coverage

As Congress debates health care reform, PHLP has issued "Uninsured Pennsylvanians" chronicling the personal struggles of eight Pennsylvanians who have little or no health insurance coverage. "Often, the uninsured are made out to be poor, lazy, unemployed, homeless, and irresponsible. In other words, not like us," said **Dr. Gene Bishop**, who interviewed the individuals and authored the profiles. "The opposite is true." According to the Congressional Budget Office, about ninety percent of the 1.3 million uninsured people in Pennsylvania go to work or live in a household where someone goes to work. Often they are not offered health insurance at work or the coverage offered is too expensive to buy. "Uninsured Pennsylvanians" is a first-hand look at the daily difficulties people without health insurance face and the reasons they do not have health coverage. To obtain a copy, visit our website-www.phlp.org.

PACE-Like Benefit Still Available for Adults on SSDI in Medicare Waiting Period

Individuals under 65 years old who have been approved for SSDI benefits and who are currently in their two year waiting period for Medicare coverage may be able to get help with their prescriptions through a program that is similar to the PACE program available to limited income individuals age 65 and older. We previously told you about this program in our March 2009 Health Law PA News.

This program is the result of a lawsuit settlement between two pharmacy benefit management companies (Caremark and Express Scripts) and the PA Attorney General's office. The $1.6 million settlement funds are being used to provide eligible individuals with low-cost prescriptions ($6 for generic/$9 for brand name) for one year. There is no income limit to qualify for this help, but someone must be receiving their SSDI cash benefit and be in their two year Medicare waiting period.

Although enrollment is limited to approximately 500 individuals, funds are still available and consumers are urged to apply for this benefit. Interested individuals should contact the Pennsylvania Pharmaceutical Assistance Clearinghouse at 1-800-955-0989 to start the application process.

Are you helping Medicare beneficiaries in plans that are terminating at the end of 2009 who are trying to understand their coverage options in 2010? If so, please visit www.phlp.org for information about Medicare in 2010. PHLP has created materials, including a chart for helping low-income Medicare beneficiaries facing plan terminations, that can help you.

If you don't have access to the internet or would like assistance with Medicare 2010 plan choices, please contact our HELPLINE at 1-800-274-3258.

New Vendor for ACCESS Plus Program To Be In Place By April 2010

The Department of Public Welfare (DPW) recently selected APS Healthcare (APS) to administer the ACCESS Plus Program and is currently in the process of negotiating a contract with the new vendor. ACCESS Plus is the Medical Assistance health care delivery system that operates in the 42 Pennsylvania counties where HealthChoices (mandatory managed care for MA recipients) does not exist. McKesson Health Solutions (McKesson) currently holds the contract and has been the ACCESS Plus vendor since the program began in 2005. DPW plans to implement the new contract on April 1, 2010.

As a reminder, the ACCESS Plus vendor is responsible for the Disease Management program for ACCESS Plus recipients with certain conditions (currently, the only conditions that qualify for disease management are asthma, COPD, diabetes, coronary artery disease, and congestive heart failure). In addition, the vendor also administers Primary Care Case Management (PCCM) services for consumers who need help coordinating their care or who have special needs. McKesson subcontracts with Automated Health Solutions to administer the PCCM component of the ACCESS Plus Program. It is not clear whether APS will also subcontract with a local vendor to provide PCCM services for ACCESS Plus.

At the same time they are getting used to a new vendor, ACCESS PLUS enrollees will be experiencing additional changes to the ACCESS Plus program that will be put in place under the new contract. For example, under the terms of the new contract, the ACCESS Plus Disease Management program will be expanded to cover many more conditions including cardiovascular and respiratory diseases, gastrointestinal diseases, rheumatic disorders and neurological disorders. In addition, the ACCESS Plus contractor will be responsible for recruiting and developing a network of dentists and specialists who are willing to treat consumers on ACCESS Plus as well as those who receive care through the MA fee-for-service system.

The Consumer Subcommittee of the Medical Assistance Advisory Committee raised concerns about the impact on ACCESS Plus participants during this transition. The consumers urged DPW to work with McKesson and APS to guarantee a smooth transition and continuity of care for Disease Management enrollees and members who use PCCM services. In response, DPW announced at the October Consumer Subcommittee meeting, that it would create a transition plan and hold joint weekly meetings with McKesson and APS during the transition period to ensure services to consumers were not delayed or interrupted as a result of the transition.

Although the vendor for the program will change, the ACCESS Plus Program's PCP provider network should not change. Consumers should be able to continue seeing their current providers even after the new contract is in place.

PHLP recently learned that McKesson lodged a protest with DPW regarding the award of the contract. Stay tuned to our future Newsletters for updates on the transition to the new ACCESS Plus vendor.

Please support PHLP by making a donation through the United Way of Southeastern PA. Go to www.uwsepa.org and select donor Choice number 10277.

Federal Health Care Reform Update

Both branches of Congress have been hard at work over the past few months crafting health care reform legislation aimed at solving the nation's health care crisis. Both the House and the Senate have drafted legislation to help provide health insurance to the 46 million Americans that are currently uninsured, as well as to lower health care costs. The House passed its health care reform bill, the Affordable Health Choices Act (H.R. 3962), after floor debate. The Senate has recently released its proposed legislation, the Patient Protection and Affordable Care Act, which was sent to the floor for debate in a 60-39 vote on strictly partisan lines.

Affordable Health Care for America Act

On November 7th, the House of Representatives passed the Affordable Health Care for America Act (H.R. 3962) by a slim vote of 220-215. The lengthy $898 billion bill now awaits action by the joint House and Senate Conference Committee for negotiations and compromise once a Senate bill is finalized and passed.

HR 3962 is similar to the proposal that was outlined in our previous newsletters and it requires all Americans to have health insurance coverage or face financial penalties. Further, along with expanding Medicaid eligibility and creating a government "public option" plan, the bill creates new health insurance exchanges designed to allow consumers who buy their own insurance to compare plans side by side. The bill also prohibits insurance companies from denying coverage to people based on their health status or imposing pre-existing condition exclusions. Most provisions of this bill would go into effect by 2013.

Patient Protection and Affordable Care Act

On November 18th, the Senate's Majority Leader Harry Reid announced the Senate's proposal for health reform, the Patient Protection and Affordable Care Act. This legislation aims to insure 31 million of the 46 million Americans currently uninsured and to add new benefits to Medicare, while at the same time reducing projected budget deficits over the next decade despite its $848 billion price tag. The Senate proposal is currently being debated.

Like HR 3962, the Senate proposal establishes a new public insurance plan to compete with private insurers but under the Senate version states can opt out of the public option by passing legislation. Unlike the House bill, the Senate proposal includes financing mechanisms such as a tax on elective cosmetic procedures, an increased tax on high-end employer-sponsored health insurance (e.g., "Cadillac") plans, as well as economic penalties on employers who do not offer health insurance to their employees (although there is no explicit requirement in the legislation that employers offer health coverage). The Senate proposal requires that most Americans obtain health insurance, but it contains less severe penalties than the House bill for those who choose to go uninsured. Furthermore, many parts of the Senate proposal do not take effect until 2014, a year later than similar provisions of the House bill.

For the text of the House Affordable Health Choices Act, visit http://energycommerce.house.gov. For more information and updates about the Senate proposed Patient Protection and Affordable Care Act visit http://dpc.senate.gov/dpcreports.cfm. We'll continue to keep you posted in future newsletters as the House bill and Senate proposal move through the legislative process toward a new health reform law.

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OMHSAS Finalizes Personal Care Home Policy

The Office of Mental Health and Substance Abuse Services (OMHSAS) recently finalized its policy on the use of, and the referral to, Personal Care Homes (PCH) for individuals with mental illness. The policy strongly discourages county mental health offices and county contractors from referring people with mental illness to PCHs with more than 16 beds. Per the policy, "It is a goal of OMHSAS that individuals be engaged and supported in identifying and moving into the most integrated housing of their choice in the community". The policy was issued and became effective August 18, 2009.

The behavioral health system has a long history of relying on referrals to PCHs to meet the housing needs of persons with mental illness. The OMHSAS policy seeks to move the system away from reliance on large institution-like PCHs by making sure that individuals are given a choice to live in small home-like PCHs which are more conducive to their recovery. In order to encourage compliance with this policy, while recognizing that some individuals may choose to live in a PCH with more than 16 beds, OMHSAS requires each County MH/MR office to develop an exceptions policy and process, in consultation with consumers and families, that outlines conditions under which a referral to a larger PCH may be allowed. Each county's exception policy must be submitted to the Office of Mental Health and Substance Abuse Services (OMHSAS) Regional Field Office for review and approval before it can be implemented. OMHSAS requires an exceptions policy to:

- Affirm the county's support for, and commitment to, the development of integrated housing options;
- Establish the parameters that would need to be met to consider an exception of a referral to a PCH with more than 16 beds; and
- Ensure the opportunity for an individual to visit at least 2 alternative housing options (which may include a smaller PCH) that would offer greater community integration than a PCH over 16 beds.

Under the OMHSAS policy, no individual can be discharged from a state hospital and referred by the county to a PCH with more than 16 beds without meeting very specific criteria outlined in the OMHSAS policy for an exception including that that the individual wishes to live in a PCH of that size, that there are no other housing options available, and that failing to make an exception would prevent the individual from leaving the state hospital. Additionally, OMHSAS requires that any individual being discharged from a state hospital who may be considered for an exception to the OMHSAS policy in order to be placed into a larger PCH must also have a Community Support Plan (CSP). The Community Support Planning process includes the individual and others of their choosing, designated hospital staff, community treatment providers and designated county mental health staff working together to determine the various services and supports available to meet the individual's needs after discharge. The CSP members must identify the rationale for any exception requested to the OMHSAS Policy. Before the CSP becomes final, it must be reported to OMHSAS for review to ensure that the individual was given a choice of housing and support options and made an informed choice to live in a PCH with more than 16 beds.

Prior to a County MH/MR Office making a referral to a PCH of any size, the OMHSAS Policy requires the county to first review the licensure status of the home. If the PCH has a provisional license, the OMHSAS Regional Field Office and DPW's Regional PCH Field Office must be consulted prior to placing someone in that PCH.

The OMHSAS policy also prohibits the use of mental health funds for new mental health programs in PCHs or for the development of Enhanced Personal Care Homes (PCHs that include additional mental health supports and are operated by community mental health providers) with more than 16 beds. For complete details on these prohibitions and to view the OMHSAS PCH Policy in its entirety go to http://www.parecovery.org/documents/PCH_Policy_OMHSAS_Final_081809.pdf.

Medicare Launches New LI NET Program

Medicare has announced it will begin a new program on January 1, 2010 that will impact how the Medicare Part D program works for full dual eligibles and anyone awarded a Low Income Subsidy (LIS). The Limited Income Newly Eligible Transition Program (commonly referred to as LI NET) combines the Medicare Part D auto-enrollment process for full dual eligibles with the Point-of-Sale process available at the pharmacy for dual eligibles and anyone with an LIS who find themselves without Part D coverage.

The Part D Auto-Enrollment Process

When Medicare discovers a beneficiary who is a full dual eligible (a person on Medicare with full Medical Assistance coverage through the ACCESS card) but who is not enrolled in Medicare Part D, it auto-enrolls the person into a Part D prescription drug plan. ***Currently***, Medicare auto-enrolls that individual randomly into one of the Part D zero-premium plans with the enrollment retroactive to the first day the person became a full dual eligible, or the first day of the last month the person had no Part D coverage (whichever is later). The Part D plan is responsible for all Part D costs incurred by the beneficiary during the retroactive period and going forward.

Beginning January 1, Medicare will use a new auto-enrollment process. Under LI NET, when Medicare learns someone is a full dual but is not in a Part D Plan, it will instead automatically enroll the person into the LI NET Plan (run by Humana) with the enrollment retroactive to the first day the person was a full dual, or the first day of the last month the person had no Part D coverage (whichever is later). The LI NET Plan will be responsible for Part D covered costs incurred by the person during the retroactive period and currently. Medicare will then auto-enroll the person randomly into one of the 2010 zero-premium plans with that enrollment going into effect in approximately two months. **Note:** the dual eligible beneficiary can always enroll into a Part D Plan on their own in which case the enrollee's plan choice prevails!

The Point-of-Sale Process at the Pharmacy

The Point-of-Sale (POS) process has been in place since the beginning of Part D to function as a safety net for low-income Medicare beneficiaries with an LIS who contact a pharmacy to fill a prescription but who do not have any active Part D coverage. This process has been referred to as "WellPoint".

When a Medicare beneficiary contacts a pharmacy and presents a prescription, the pharmacy will check the Medicare system to see if the person is enrolled in a Part D Plan. ***Currently,*** if the system shows no Part D enrollment, and the consumer can show that she is either a dual eligible or that she has been awarded an LIS, the pharmacist can submit a claim through the POS process and be paid (and just charge the consumer the small co-pay she has with her LIS). The POS process can continue to be used until Medicare randomly enrolls the consumer into a Part D zero-premium plan or until a consumer joins a Part D plan and the coverage becomes effective (whichever happens first).

Beginning January 1, the POS process will become part of LI NET and therefore be run by Humana and not WellPoint. Under LI NET, when a pharmacy successfully submits a claim through the POS process for a low-income beneficiary who is not currently enrolled in a Part D Plan, the beneficiary is immediately enrolled into LI NET which will pay the claim and provide at least some retroactive coverage. In addition, LI NET will provide ongoing coverage for a temporary period until Medicare auto-enrolls the person randomly into one of the 2010 zero-premium plans with that enrollment going into effect in approximately two months. Again, the low-income beneficiary can always enroll into a Part D Plan on their own in the meantime in which case the enrollee's plan choice prevails!

The actual steps the pharmacy must take to submit a POS claim in 2010 under the new LI NET system will be available on PHLP's website (www.phlp.org) before the end of the year. Individuals can contact our HELPLINE (1-800-274-3258) in January if they need help accessing medications under the LI NET process.

PHLP Staffer Receives Award from ACHIEVA

Erin Guay, a paralegal in PHLP's Pittsburgh office, was recently the recipient of a 2009 Award for Excellence in Professional Legal Service from ACHIEVA -an organization that provides lifelong supports to individuals with disabilities and their families in western Pennsylvania. Erin was recognized by ACHIEVA for her effective advocacy over the past 5 and ½ years in helping ACHIEVA's clients with intellectual and developmental disabilities obtain the health care coverage and services they need to thrive in their communities. Congratulations Erin on receiving this well-deserved award!

PHLP will be closed for the Holidays from 1:00 pm on Thursday, December 24, 2009 through Friday, January 1, 2010.
We will re-open at 9 am on Monday, January 4th.

We wish everyone Happy Holidays and a Health New Year!

PHLP is a small non-profit 501(c)(3) law firm. We encourage you to consider us when making any year-end contributions to charitable organizations.

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