Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

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On the Internet: www.phlp.org

Volume 9, Number 4 September 2006

Recertifying Eligibility for the Medicare Part D Low Income Subsidy (LIS) Now Underway

Enrolling into a Medicare Part D plan involves significant cost-sharing by the consumer. Typically, this includes monthly premiums, an annual deductible, co-pays and a "donut hole" (a period when the consumer must pay 100% for their drugs). Medicare beneficiaries with low income and assets, and those who are dual eligible (on Medicare and also receiving some help from Medical Assistance) are eligible for a Low Income Subsidy (LIS) that will eliminate, or greatly reduce, their Part D costs. The federal government is now beginning the process of recertifying consumer eligibility for the LIS for 2007. The process will affect those who previously applied for the LIS and were approved as well as those who were automatically deemed eligible for the LIS because they are dual eligible.

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INSIDE THIS EDITION

PACE Plus Medicare Began September 1, 2006

Approximately half of PACE and PACENET members were auto-enrolled into Part D plans for coverage starting September 1, 2006. PACE/PACENET is now the secondary prescription drug coverage for these members and will help pay for Part D costs. The PACE/PACENET programs will also wrap around other Part D coverage for those members who were not auto-enrolled into plans by PACE/PACENET but who have Part D coverage already through a stand-alone drug plan or through a Medicare HMO that

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Gearing Up for Year Two of Medicare Part D

Year Two of Medicare Part D is almost upon us. The Open Enrollment Period for enrolling into a Part D plan for 2007 is November 15th through December 31st, 2006. During that time Medicare consumers can either change their Part D plan or enroll in Part D for the first time (if they missed the initial enrollment deadline of 5/15/2006).

Part D Plan Information

By the beginning of October, the Center for Medicare & Medicaid Services (CMS) will announce which Part D plans will be participating in the program in 2007. Information will then be available on the premiums, deductibles and co-pays each Plan will charge in 2007. This 2007 Plan information is also expected to be available on the Medicare website, www.medicare.gov in mid-October. The 2007 Plans can then begin their marketing activities in October.

Zero Premium Plans

Once the 2007 plan information is announced, we will know which stand-alone standard prescription drug plans will have premiums below the benchmark premium. The benchmark monthly premium for 2007 is $28.45. These standard plans (also known as zero premium plans) are the ones that dual eligibles and those who qualify for the Low-Income Subsidy (LIS) can join without having to pay a monthly premium.

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Which Definition of Medical Necessity Applies?

The question of the applicable definition of medical necessity in Fee-for-Service preferred drug list cases has come up several times in recent Consumer Subcommittee meetings of the Medical Assistance Advisory Committee. According to the state regulations that govern Medical Assistance, the definition of medical necessity is:

Medically necessary—A service, item, procedure or level of care that is:

(i) Compensable under the MA Program.

(ii) Necessary to the proper treatment or management of an illness, injury or disability.

(iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice. (55 PA Code § 1101.21

Under HealthChoices, the definition is broader:

Medically Necessary: A service or program is medically necessary if it is compensable under the Medical Assistance program and if it meets any one of the following standards:

- The service or benefit will or is reasonably expected to, prevent the onset of an illness, condition, or disability.
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist

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The Candidates for Governor on Health Care

PHLP has reviewed the websites of the two major candidates for Governor of Pennsylvania to see what they say about health care. Here's what we found:

The Republican candidate, Lynn Swann, promises tort reform as a way of improving access to health care in Pennsylvania. He says that tort reform is needed to keep medical professionals in the state and he supports a cap on non-economic damages in civil suits. He also points out that while the number of people on Medical Assistance went down under Governor Ridge, MA caseloads are up 320,000 under Governor Rendell.

Democrat Ed Rendell's website points to PACE and PACENet expansion to exemplify his commitment to improve health care access. It points to more in-home services for seniors and the institution of certification requirements for home health workers as accomplishments. And the website contains a newspaper article touting the Cover All Kids initiative which would make Pennsylvania one of only three states to extend health insurance to all children.

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includes Part D coverage. For some members, this help started on September 1, 2006; for other members, this help will start over the next couple months. These members will receive a notice from their Part D plan and PACE that explains how PACE will work with their Part D coverage and help with the costs of that coverage. These notices will also let members know when this help will begin.

How PACE Plus Medicare Works for PACE Members Auto-enrolled into Part D Coverage

Starting September 1st, these consumers must show both their Part D plan ID card and their PACE card at the pharmacy. The pharmacy will bill their Part D plan first and then bill PACE second. The individual should pay no more than $6 for generic medications or $9 for brand name medications at the pharmacy (as long as the medication is covered by the PACE program). In addition, PACE will pay the monthly premium to the Part D plan.

How PACE Plus Medicare Works for PACENET Members Auto-enrolled into Part D Coverage

As of September 1st, these consumers must show both their Part D plan ID card and their PACENET card at the pharmacy. The pharmacy will bill the Part D plan first and PACENET second. The individual should not pay more than $8 for generic medications or $15 for brand name medications at the pharmacy (as long as the medication is covered by the PACENET program). These individuals **will** have to pay the monthly premium to their Part D plan, but they will no longer have the $40 monthly

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DPW Establishing Peer Support Services as a Medicaid Funded Service

In 2002, the final report of the President's New Freedom Commission on Mental Health stressed the critical need for transformation of the mental health system and the need to develop consumer driven, recovery-oriented services. As a result, DPW's Office of Mental Health and Substance Abuse Services (OMHSAS) has engaged in a statewide system transformation initiative, which focuses on the provision of recovery-oriented mental health and co-occurring (psychiatric and substance abuse disorders) services throughout the commonwealth.

As part of this statewide transformation, DPW/ OMHSAS, is establishing Peer Support Services as a Medicaid reimbursable service. Peer Support Services are peer-to-peer, person-centered and recovery focused services for adults 18 and older, provided by individuals who have utilized the behavioral health system. Peer Support provides a range of services based on the needs of the individual that can include, advocacy, education, the development of natural resources, crisis support, linkage to other services, and support of work or other meaningful activities of the person's choosing.

Last year, OMHSAS staff researched several other states that currently provide Peer Support Services through Medical Assistance. This information was compiled and presented by OMHSAS to all interested stakeholders last September in an Orientation Session. Following the Orientation Session, a Peer Support Services

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Dangers of Medicaid "Personal Responsibility" Agreements

Gene Bishop, M.D., physician consultant to the Pennsylvania Health Law Project, warns of the dangers of West Virginia Medicaid's new policy of requiring Medicaid recipients to sign documents outlining "member responsibilities and rights." An article co-authored by Dr. Bishop and Amy C. Brodkey, M.D., which appears in the August 24, 2006 New England Journal of Medicine, says the plan: places responsibility on patients for factors that may be out of their control, holds Medicaid patients to a standard of behavior not required of other patients, and asks physicians to violate all three fundamental principles of the Physician Charter on Medical Professionalism. The article can be viewed online at: http://content.nejm.org/ The article is timely as states, including Pennsylvania consider how to use the flexibility afforded them by the federal Deficit Reduction Act.

DPW Moves to Fix Erroneously Charged Copayments on Medical Supplies

Last October, a technological glitch caused DPW to start erroneously charging copayments for medical supplies under the fee for service system. PHLP raised this issue with DPW after it was identified by a health care provider. DPW believes that it has fixed the problem prospectively, and is considering other remedial action.

Please post this notice

The Pennsylvania Health Law Project
invites you to a presentation on:

Medicare Part D– Year 2: What does it mean for low-income consumers?

The Pennsylvania Health Law Project Help-Line
1-800-274-3258; TTY : 1-866-236-6310

PHLP will hold FREE trainings for advocates and providers on ***new*** Part D issues:

- Low-income subsidy ("extra help") redeterminations: The process for redetermining eligibility for the low-income subsidy for individuals approved by Social Security and for dual eligibles starts in September. Notices will start going out to consumers in early September, so make sure you know about these processes!

- PACE Plus Medicare:
  PACE enrolled about half of their members into Part D plans for coverage starting September 1, 2006.

Training dates scheduled so far are:

Monday, October 23rd (Chester county)
10am— 11:30am
Chester County Library
450 Exton Square Parkway
Exton, PA 19341

Tuesday, October 24th (Bucks county)
10:30am—12:00pm
Bucks County Library– Pennswood Branch
301 S. Pine Street (Rt. 413 and Flowers Ave.)
Langhorne, PA 19047-2887

Monday, November 6th (Philadelphia county)
10am—12pm
Philadelphia Bar Association
1101 Market Street, 11th Floor
Philadelphia, PA 19107

Training to be announced in Delaware county!

Please Call the Pennsylvania Health Law Project to RSVP so that we know how many people to expect:
1-800-274-3258
TTY: 1-866-236-6310
Or email:
jnix@phlp.org

Visit us online at
www.phlp.org

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> the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for Members of the same age (HealthChoices Standard Agreement, Section II)

During the discussions about the possible carve out of pharmacy from HealthChoices, consumers raised concerns about the application of the Fee-for-Service definition of medical necessity. This would have been a change for consumers who were in HealthChoices- the need for their physical health services would be governed by the HealthChoices definition but their need for prescription drugs would be governed by the Fee-for-Service definition of medical necessity. At the time, the Department of Public Welfare indicated that it already applied the HealthChoices definition in evaluating the medical necessity of drugs under fee-for-service. Additionally, DPW indicated that it was working on a regulation change that would make the HealthChoices definition the governing definition in Medical Assistance.

While the legislature has determined that there will be no pharmacy carve out, the question remains, which definition should apply under the fee-for-service program? The Department's regulatory agenda, published last June, indicates that a regulatory change to the HealthChoices definition is to be proposed ion the PA Bulletin in February, 2007. The process takes many months, however.

And while the Department may be using the HealthChoices definition internally, the definition being applied by ALJs at administrative hearings is the stricter definition found at in 55 PA Code § 1121.

The Consumer Subcommittee of the MAAC has asked DPW to issue a written policy directive to clear up the confusion in the interim.

Public Hearings on Cover All Kids

Various legislative committees have been holding hearings on the Cover All Kids initiative. On September 19, the Senate Banking and Insurance Committee and the Senate Public Health and Welfare Committee held a joint hearing.

The initiative, which when fully implemented would make health insurance available to all children in Pennsylvania through an expansion of CHIP, has been budgeted for the current fiscal year, but is awaiting enabling legislation. At present, 133,000 kids in Pennsylvania are without health insurance. This represents 15% of all uninsured Pennsylvanians. By raising the income limit for CHIP subsidy from 235% to 350% of the Federal Poverty Income Guidelines, and offering CHIP coverage at cost to those above the limit, no child should be without health insurance. This year's CHIP budget increase of $14.6 million ($4.4 million in state dollars and $10.2 million in federal dollars) is expected to result in the enrollment of 15,000 more children.

The Democratic Policy Committee is holding a hearing on this subject on October 11 in Lancaster at the 10:00 AM in the City Council Chambers.

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Redetermining Eligibility for LIS Applicants

Under the Medicare Modernization Act, the Social Security Administration (SSA) is required to redetermine LIS eligibility within the first year of Medicare Part D. That redetermination process is now underway and will affect only consumers who applied for the LIS and were approved **before May, 2006**.* These consumers were mailed a Notice of Review from SSA in early September telling them their LIS eligibility is being reviewed. The notice lists the person's income, resources and household size (according to SSA records).

- **If the information in the notice is correct**, the consumer does not need to respond or take any action. SSA will then do a data match to make sure the information is correct
  - If the data match confirms no change, SSA will redetermine the person LIS eligible at the same level for calendar year 2007 (no confirmation letter is sent, however)
  - If the data match indicates there has been a change, SSA will then send the consumer a Redetermination questionnaire which must be completed and returned within 30 days

- **If the person's circumstances have changed and the information in the notice is not correct,** the person must mail back the enclosed form (or call SSA) within 15 days indicating there has been a change. SSA will then send the consumer a Redetermination questionnaire that must be completed and returned within 30 days.

Once the Redetermination questionnaire is received, SSA will review the information and do a data match to verify the information.

- If the consumer is determined eligible for a LIS at the same level they had previously been awarded, the LIS will be redetermined through calendar year 2007 (no confirmation letter is sent, however)

**anyone determined eligible for LIS from May, 2006 on will remain eligible and not be redetermined until August, 2007!*

- If the consumer's level of subsidy changes, or if he is determined no longer eligible for a LIS, a notice of change/ termination is sent by SSA to be effective 1/1/2007

If the consumer receives a Redetermination questionnaire that she fails to return within 30 days, SSA will contact her once more by mail notifying her that her LIS will be automatically terminated 12/31/2006 unless the questionnaire is completed and returned.

Remember: A consumer has 60 days to appeal from a determination that their LIS will be reduced or terminated. If the person appeals quickly (within 10 days of the receipt of the determination) they can continue to receive the LIS at the same level as before pending a final decision on their appeal. If the appeal timeframes have passed, or if the person's circumstances change, they can reapply for the LIS at any time.

"Re-deeming" LIS Eligibilty to Dual Eligibles

All dual eligibles (even those who only get help with their Part B premium through the Medicare Savings Program) are "deemed" eligible for a full LIS. "Deemed" means they are awarded the LIS automatically and do not need to apply for it. The Center for Medicare and Medicaid Services (CMS) receives a monthly file from the states listing all dual eligibles and

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must annually "re-deem" their LIS eligibility.

The "re-deeming" process for 2007 has begun. The process is based on the July 2006 state data files. CMS is currently reviewing the lists of all persons identified as dual eligible in July, 2006:

- Those previously deemed LIS eligible who appear in the July files will be "re-deemed". They will be sent a notice from CMS that their LIS will continue through December, 2007.
- Those previously deemed who do not appear in the July files will be sent a notice that their deemed LIS status will end on 12/31/2006. Note: If any of these persons go back on MA and become dual eligible again after July, 2006 they should get another notice telling them they are deemed LIS eligible again through December, 2007.

Those who are identified as dual eligible for the first time in the July files (or in files for later months) will be deemed LIS eligible retroactive to the first month they became a dual eligible and through December, 2007.

Remember: If a consumer is no longer dual eligible and loses their "deemed" status, it only means the person no longer automatically qualifies for the LIS. These persons can still file an application for the LIS with SSA and they will receive a decision whether they qualify based on their income and resources.

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Medicare beneficiaries with a LIS who were assigned to, or who enrolled in, a zero premium plan in 2006 will be sent a notice from CMS later in the Fall if the Plan they are in will no longer participate in Part D in 2007, or if the Plan will not be a zero premium plan in 2007. These consumers will be told they can:

- Choose to stay in the Plan (if it will still be participating in Part D in 2007) but they will then have to pay part of the premium;
- Enroll into another Plan of their choice; or
- If they do not make a choice by 12/31/2006, they will be auto-enrolled by CMS into another zero-premium plan effective 1/1/2007

Increased Costs for LIS Eligibles

The costs of Part D will increase in 2007 for those who are dual eligible or who otherwise qualify for a LIS. The annual deductible for those who qualify for a partial subsidy will increase from $50 to $53. The prescription co-pays charged to those with a LIS will increase as follows:

- $1 co-pay will stay at $1
- $2 co-pay increases to $2.15
- $3 co-pay increases to $3.10
- $5 co-pay increases to $5.35

Our next Newsletter will have updated information on the 2007 Plans and how you can help the consumers you work with choose the best plan for them for 2007.

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PACENET deductible to pay at the pharmacy.

Other information about PACE Plus Medicare

For both PACE and PACENET members who were auto-enrolled into Part D plans by the Program, they now must go to a pharmacy that accepts their Part D coverage. If the pharmacy does not accept an individual's Part D plan, then they will be denied medication at that pharmacy and will need to go to a pharmacy that does accept their Part D plan coverage. Hopefully, this should not be a problem for many consumers since PACE/PACENET considered pharmacy usage during the auto-enrollment process.

The Part D plans that are partnering with PACE for the PACE Plus Medicare program have agreed to not apply prior authorization or step therapy requirements to PACE/PACNET enrollees. Therefore, individuals hopefully will not be denied medication at the pharmacy for these reasons.

PACE/PACENET enrollees who have Part D coverage must use the Part D coverage first. If the pharmacy tries to bill PACE without billing Part D first, then the medication will be denied and pharmacists will be instructed to bill the Part D plan first.

PACE/PACENET will pay for medications that are not covered by an individual's Part D plan as long as it is a medication that the Program currently covers.

PACE/PACENET enrollees who do not have Part D coverage

Some individuals with PACE and PACENET were not auto-enrolled into Part D (including those who declined the auto-enrollment) and do not have other Part D coverage. For these individuals, PACE is continuing as work as it has in the past with no change. PACENET is also continuing with a slight change: the $40 monthly deductible has been eliminated and is replaced by a $32.54 monthly premium due at the pharmacy.

If you have any questions about the PACE Plus Medicare program or if you are having any problems accessing prescriptions under this new program, you can call the PACE/PACENET program at 1-800-225-7223. You can also contact the PA Health Law Project Helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

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Workgroup was formed and met for four months to development the state plan amendment that was submitted to CMS in December.

Although DPW has not yet received final approval from CMS authorizing Peer Support Services as Medicaid reimbursable, OMHSAS is proceeding, expecting they will. A draft bulletin was released for public comments in August for Peer Support Services Implementation and Medical Assistance Payment Guidelines. The 26-page Bulletin outlines the general guidelines for provider participation and responsibilities, consumer eligibility, medical necessity guidelines, staffing patterns and enrollment and payment guidelines. OMHSAS received 31 sets of comments, which they are currently reviewing before re-issuing the Bulletin.

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PHLP Part D List-Serve for Advocates and Professionals Working with the Disability Community in Southwestern PA

PHLP's Pittsburgh office will maintain an e-mail list-serve on Medicare Part D available to advocates and other professionals working with consumers with physical, sensory, and/or developmental disabilities in the following 10 counties in Southwestern PA: Allegheny, Armstrong, Beaver, Butler, Fayette, Green, Indiana, Lawrence, Washington, and Westmoreland.

The purpose of this list-serve will be to update professionals and advocates regularly on Part D developments and program changes. The list-serve will also be a forum for professionals and advocates to engage in ongoing discussions on Part D and to:

- raise Part D questions;
- identify specific problem areas for consumers with disabilities and collaborate on potential solutions to identified problems; and
- learn of local and statewide advocacy opportunities.

The primary focus of this list-serve will be on Medicare Part D; however, the list-serve will also address questions and issues on how dual eligible consumers access care as a result of the Part D changes (i.e, transition to fee-for-service Medicaid and enrollments in Medicare Special Needs Plans).

If are interested in joining this list-serve, please send an e-mail to Erin Guay at eguay@phlp.org or call the PA Health Law Project Helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

UPMC Pulling out of Voluntary HealthChoices Counties

UPMC is pulling out of four counties where it operated voluntary MA managed care plans. The four counties are Blair, Cambria, Somerset and Venango. This will affect about 4,400 people in total, though about half are in Venango county. The pullout is scheduled to be effective on October 1, 2006, though DPW has said that if necessary, the date could be extended to November 1, 2006.

Notices have gone out to affected consumers letting them know their options. In counties where there are other voluntary managed care organizations, consumers have been given the choice of moving into another voluntary HMO or moving into Access Plus. However, in Venango county, where the most consumers are affected, there are no other managed care plans. In that county, all consumers will be moved into Access Plus/ Fee-for-Service. Nonetheless, affected persons in Venango County need to select a primary care practitioner (PCP).

Who Is on Medicaid in Pennsylvania?

DPW's August statistics show that over half (51.5%) of the state's Medicaid population is children. In ten counties, at least 20% of the population is on MA: Cameron, Clearfield, Erie, Fayette, Greene, Jefferson, McKean, Philadelphia, Potter and Venengo.

PHLP Staff Available for Free Medicare Rx Trainings

PHLP staff are available in Southwestern and Southeastern PA to conduct trainings on Part D to help social service agencies and their clients navigate the Part D system. Trainings focus on the rights that dual eligibles have under Part D and the appeals and grievance processes that are available to all Part D enrollees. To learn how to help get your clients' needs met through Medicare Part D, contact the PHLP HELPLINE to schedule a training (1-800-274-3258 voice or 1-866-236-6310 TTY). Please let us know if you require any special accommodations for persons with hearing and/or vision needs.

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OMHSAS also developed the training curriculum required for Peer Support Services certification and requested each county to recruit two interested consumers to be trained. The counties responded and the two-week intensive training has already occurred for the first groups of potential Peers Support Specialists. OMHSAS anticipates that Peer Support Services will be in place as Medicaid reimbursable by December 2006 or January 2007.

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