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Changes in Medical Assistance & Medicare

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Medicaid and Medicare provide health care coverage for more than one fourth of all Americans. Medicaid has undergone major changes in 2005 and Medicare added a prescription drug benefit plan on January 1, 2006. Due to years of rapidly growing costs and shrinking federal funding that threatens to erode patient care, PA's Medical Assistance (MA) programs are in financial trouble. Policymakers have been forced to wrestle with the problem while resolving to make changes as painless as possible for the poorest and most vulnerable Pennsylvanians.

ACCESS PLUS

In the spring of 2005 PA's Department of Public Welfare (DPW) converted over 250,000 fee-for-service MA recipients located in 42 mostly rural counties to Access Plus. DPW continues to oversee the mandatory managed care programs operating in the remaining 25, mostly urban, counties. Access Plus is a primary care case management system contracted by the Commonwealth. The goals of the programs are to improve access to health care, improve quality of available health care and to stabilize MA spending.

All MA recipients living in the 42 counties must enroll in Access Plus with the exception of the following:

- Individuals enrolled in a MA Voluntary Managed Care Organization (VMCO);
- Individuals participating in the Health Insurance Premium Payment Program (HIPP);
- Individuals over the age of 21 who have MA and Medicare; or
- Individuals who reside in nursing homes.

Primary Care Physician.
A MA recipient, if not included in one of the above-mentioned categories, must choose a Primary Care Physician (PCP). If a recipient fails to select a PCP, one will be chosen for him/her. If this happens or for some other reason, the recipient opts for a different PCP, a new PCP can be chosen at any time.

Selecting a PCP that the consumer feels comfortable with is important. This is the physician s/he must rely on to make referrals to other health care professionals. For example, to seek the help of a specialist, a referral must be made by the PCP. Except for emergencies, a PCP referral must be supplied before services can be obtained at a hospital.

PCP referrals are not needed for dental care, family planning, OB-GYN care or emergency care at the hospital. Mental health services are not included in Access Plus.

Persons requiring treatment for mental health issues should contact their county's mental health program. For drug and/or alcohol treatment, the county's drug and alcohol program should be contacted.

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Disease Management. Under the Disease Management program additional services are available through Access Plus. A person diagnosed with asthma, diabetes, coronary artery disease, congestive heart failure or chronic obstructive pulmonary disease may receive services for the purpose of disease management. The PCP must notify Access Plus of the disease and the type of treatment the patient receives will depend on how far the disease has progressed.

RAC Meetings. Regional Advisory Committees (RAC) meet on a regular basis for ACCESS Plus consumers, providers and advocates to raise issues, discuss the program's pros and cons, strengths and weaknesses and offer suggestions for improvement.

Attorney Susan Michalik of MidPenn's State College office is a member of the North Central RAC. Ms. Michalik encourages others, especially MA recipients who have first hand knowledge of the system, to attend these meetings. North Central RAC meetings are held in State College, lunch is provided and participants are reimbursed for mileage. If you have an interest in participating in these meetings contact Ms. Michalik at 800-326-9177.

CHANGES IN MA

On August 29, 2005 more profound changes became effective in the 42 fee-for-service counties. Actual medical services provided under MA were cut for recipients with the **exception of children under the age of 18, pregnant women or persons in nursing homes**. The changes include caps on service, co-payments and on October 1, 2005 a Preferred Drug List was implemented. Regardless of when these changes took effect, they concur with the fiscal year that runs July 1 through June 30. These changes are likely to be adopted soon for MA recipients in Managed Care Counties.

Caps on Service. For adults receiving Supplemental Security Income (SSI) or Temporary Assistance for Needy Families (TANF) benefits, there is no limit on the number of inpatient hospitalizations that MA will cover in a year. For adults on General Assistance (GA), inpatient hospitalizations are limited to 1 per year instead of 2 as in previous years. Rehab hospitalizations are limited to 1 inpatient rehab hospitalization per year regardless if an adult patient is receiving SSI, TANF or GA. There is no change in the number of doctor's visits GA recipients receive, but for SSI and TANF recipients are now limited to 18 visits per year. Every MA recipient is restricted to 30 days per fiscal year for inpatient psychiatric hospitalizations instead of 60 days. Psychiatric outpatient clinic services are limited to 5 hours or ten 30 minute sessions per month for all MA recipients instead of 7 per month. Partial psychiatric hospitalizations, for all categories of MA , are limited to 540 hours per year, down from 720 hours in prior years.

Co-payments for Drugs. As with caps on services, co-pays do not apply to MA consumers under the age of 18 years, women who are pregnant and residents of nursing homes. Co-payments do apply to all other adults on Access Plus MA. They are responsible for paying $1 for each generic prescription and $3 for a brand name. If co-pays exceed $90 in a 6-month period, DPW will reimburse the amount in excess of $90 to the recipient.

Preferred Drug List. A Preferred Drug List, that includes both physical and mental health drugs, was put into place on October 1, 2005 in some counties. Remaining counties will be added gradually. This list limits the choices of drugs health care providers can prescribe for MA patients. The recipient and/or the physician will need to request an exception to get any drug not on the list. If DPW denies the request, the decision can be appealed.

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Exceptions. There are exceptions to these new rules. Individuals who need health coverage that exceed the new limits can apply for an exception. DPW can grant an exception if:

- The recipient has a serious chronic systematic illness or other serious health condition and denial of additional services could result in the condition worsening or possibly in loss of life;
- The recipient will need more expensive services if the exception is not granted; or
- The recipient would have to go into a nursing home or other institution if the exception is not granted.

Managed Care Lock-In & 6 Month Re-determinations. One change that is specific to Managed Care came as a surprise to consumers and advocates alike. In a concession to the HealthChoices HMOs, the welfare code was amended to lock consumers into their HealthChoices HMO for a year at a time. This rule does not apply in voluntary (non-HealthChoices) HMO counties.

The law also requires DPW to review MA eligibility for many MA recipients every 6 months in place of the current annual re-determination. Consumers and advocates had argued that these re-determinations had been proven to be burdensome and costly to recipients. There are 7 categories who are excluded from the 6 month eligibility re-determination. Contact your local county assistance office for further information.

MEDICARE D

All persons with Medicare Part A and/or Part B are eligible for prescription drug coverage. Enrollment, which began on November 15, 2005, is voluntary. To allow for enough time to review all plans being offered, enrollment runs until May 15, 2006. Enrolling late will result in late fees which accrue for every month the enrollment is delayed. If an individual is covered under an insurance plan that provides equal or superior drug coverage (creditable coverage) to Medicare D, the decision to enroll can be delayed until such time the creditable coverage is no longer available to the recipient. In this instance postponing enrollment in Medicare D will not result in penalties.

Under Medicare D, monthly premiums and annual deductibles must be paid by participants. Forecasts for 2006 project an average monthly premium of about $37. In 2006 the deductible is set at $250. Once the deductible has been met, other factors come into play. For instance, Medicare D pays only 75% of your prescription purchases up to $2,250. The participant is responsible for the remaining 25%. When $2,250 is reached, the participant is responsible for payment for drugs totaling $2,850. When this threshold is met, the "catastrophic" limit, Medicare will again pay 95% of the remaining drug costs and the participant will only be responsible for a co-payment of either $2 for generic or $5 for brand name drugs ,or 5%, whichever is greater.

There is extra help for people with limited income and resources who can't afford the out-of-pocket expenses. This help will come in the form of subsidies. Almost 1 in 3 people with Medicare will qualify for extra help and Medicare will pay for almost all of their prescription drug costs. Applications for subsidies can be obtained from the Social Security Administration.

If you have questions and/or need help with the information sent by the Social Security Administration, contact Pennsylvania's APPRISE insurance counseling services. These services are FREE and the APPRISE counselors will provide advice regarding the Medicare Part D Benefit. Call toll-free, 1-800-783-7067 to speak to an APPRISE counselor.

For answers to specific questions, contact Medicare at 1-800-633-4227 or visit Medicare online at www.Medicare.gov.

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