Legal Aid Society
OF THE DISTRICT OF COLUMBIA

May 22, 2009

Dr. Julie Hudman
Director
DC Department of Health Care Finance
825 North Capital Street NE
5th Floor
Washington, DC 20002

Re: Proposed Alliance Eligibility Regulations

Dear Dr. Hudman:

The Legal Aid Society has reviewed the proposed changes to the Alliance eligibility regulations published in the DC register on April 24, 2009. *See* DC Register Vol. 56-No. 17, 4/24/2009, pp. 003160 – 003161. Thank you for the opportunity to submit these comments to the proposed regulation.

The Health Care Alliance program is one of the best examples of the District's on-going commitment to health care access for low-income residents. Without the Alliance program, tends of thousands of people would have no meaningful access to comprehensive health care services. As we have discussed previously, Legal Aid does not oppose responsible efforts by the Department of Health Care Finance (DHCF) to limit Alliance eligibility to those who the program was intended to serve.

However, we are concerned that the proposed regulation, as currently written, will terminate Alliance benefits for individuals who do not have other access to comprehensive health care benefits. Terminating Alliance coverage for those without other access to care would be contrary to the purpose of the Alliance program, which is to provide comprehensive health care services to those without other access to care. *See* D.C. Code § 7-1405(a); *see also* D.C. Code Mun. Regs. § 22-3399.1 (both the statutory authorization and the regulations clearly state that the purpose of the Alliance program is to provide comprehensive health care access).

These comments will address the following concerns related to the structure and content of the proposed regulations:

1) DHCF should not terminate Alliance benefits for enrollees who are deemed "eligible" for Medicare until all of their Medicare coverage becomes effective. If people are removed from the Alliance program before their full Medicare benefits (meaning Medicare Parts A, B and D) become effective, they will have no way to access critically important primary and preventive health services.

2) DHCF should not terminate Alliance benefits for enrollees who become enrolled in the Qualified Medicare Beneficiary (QMB)

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program until they are also enrolled in Medicare Parts A, B and D. Although QMB enrollment is an important step in the Medicare buy-in process, QMB is not health insurance, but only a cost-sharing program. Individuals with only QMB will not be able to access health services until their Medicare also becomes effective. While waiting for Medicare, these individuals will need continued coverage by the Alliance program.

3) DHCF should ensure that people will not be removed from or denied Alliance coverage because of Emergency Medicaid coverage. Emergency Medicaid is not the same thing as full-scope Medicaid, and does not offer access to comprehensive health care services. Emergency Medicaid only pays for costs related to a medical emergency for certain immigrants who do not qualify for full-scope Medicaid. Those who receive Emergency Medicaid will still need Alliance coverage to obtain non-emergency medical care.

4) DHCF should define the phrase "other 3rd party coverage" to exclude highly restrictive health coverage plans, such as those that provide only catastrophic coverage (and no primary care benefits). The purpose of the Alliance program is to provide comprehensive health coverage to those without such coverage. Removing those with a very limited health benefit from the comprehensive benefits of the Alliance would defeat the purpose of the program.

These comments will also address an implementation concern: DHCF should ensure that those who are transitioned from the Alliance (and Medicaid) to Medicare receive assistance selecting the most appropriate Medicare Part D prescription drug plan. If affected individuals do not affirmatively choose a plan, which can be a difficult and complicated process, they will be randomly enrolled in a plan that may not cover the drugs they need (or that place restrictions on covered drugs). To prevent disruptions in people's prescription drug access, DHCF should arrange for those transitioned into Medicare to receive individualized assistance with selecting a Part D plan.

These comments will identify the parts of the proposed regulation that should be clarified and/or modified, and propose ways DHCF can effectively address these issues.

The Department's Proposal:

In its entirety, the new eligibility regulation for the Alliance program reads as follows:

> Eligibility for the D.C. HealthCare Alliance is limited to residents of the District of Columbia who are not eligible for Medicaid or Medicare or are not enrolled in any other

third party health insurance program, and who live in households:

(a) With a countable income of less than 200 percent of the Federal Poverty Level; and

(b) With countable resources less than $ 4,000 (or $ 6,000 if the individual lives with a spouse or cares for a child who is residing in the home).

See DC Register Vol. 56-No. 17, 4/24/2009, pp. 003160 – 003161.

Comments and Recommendations Related to the Proposed Language of the Regulation:

Legal Aid recommends that DHCF address the following concerns raised by the above proposed regulation:

I. The regulation should be amended to clarify that Alliance coverage will only terminate for individuals enrolled in Medicare Parts A, B and D.

The proposed regulation states that a person must be "eligible" for Medicare to be disqualified from Alliance coverage. Medicare "eligibility," however, is not the same thing as Medicare "coverage" or "enrollment." The proposal, as it is currently written, would likely remove people from the Alliance program before they are actually enrolled in Medicare Parts A, B and D.

For a variety of reasons, many people who are technically "eligible" for Medicare may not have Medicare "coverage" through Parts A, B and D, meaning they cannot actually access health care services. For instance, some people may have only partial coverage through Medicare, such as Part A or Part B only, even though they are eligible for complete Medicare coverage through their receipt of Social Security Retirement benefits. Others may not automatically qualify for any Medicare coverage (*i.e.* someone who does not qualify for Social Security Retirement benefits). Such individuals, however, can still "buy in" to both Medicare Parts A and B. *See* 42 U.S.C. §1395i-2(a) (describing eligibility for Medicare Part A for otherwise ineligible elderly individuals); *see also* 42 U.S.C. §1395o (describing eligibility for Medicare Part B for individuals who are not automatically entitled to Medicare Part A). If DHCF terminates Alliance coverage because an individual is eligible for Medicare, he or she could be without access to health care services for a significant period of time.

If DHCF plans to terminate Alliance coverage for individuals who the agency expects to receive Medicare coverage, DHCF should clarify that such removals will occur only after someone's Medicare coverage under Parts A, B and D becomes effective. The District, as well as current Alliance enrollees, would benefit from such a policy because the District will have an incentive to ensure that the transition to Medicare

occurs as soon as possible by monitoring cases and responding quickly to problems. Making the buy-in process work more efficiently will in turn allow the District to realize associated savings as soon as possible without sacrificing this population's access to essential health care services.

Sections a. and b., below, discuss how the Medicare buy-in works, and why those buying-in to Medicare will need continued Alliance coverage during that process.

a. DHCF should allow those with only QMB and Medicare Part A to keep their Alliance coverage until they also have Part B coverage.

When a person automatically qualifies for Medicare, he or she has the right to refuse Medicare Part B coverage, and only receive hospital benefits through Medicare Part A. *See* 42 C.F.R. § 407.17(b) (2009) (stating that a person may decline Part B coverage by submitting a signed statement to Social Security or CMS saying he or she does not want coverage). Legal Aid routinely encounters people who have rejected Part B coverage out of concern for their ability to pay the monthly premium. Such individuals are usually not aware that the QMB program exists, or were not eligible for QMB at the time they rejected Part B coverage. These individuals then end up enrolling in the Alliance because that is their only way to access primary care physicians, certain specialty care, and other outpatient services.

Enrolling someone with only Medicare Part A into QMB allows them to buy-in to Medicare Part B and eventually receive access to non-hospital health care services. *See* District of Columbia State Plan for Medical Assistance, Attachment 3.2-A, § (A)(3) – (4) (pg. 1) (1990); *see also* Modification No. 1 of Agreement with the State, § A(8)(a)(ii) (1979) (*hereinafter* "Buy-in agreement") (describing one "coverage group" as those eligible for medical assistance under the District's state plan). The buy-in process, however, is not immediate, and while a person's Medicare Part B coverage is pending, he or she will have no access to primary health care benefits without Alliance coverage.

Delays associated with the buy-in process mean that Part B coverage does not begin at the same time a person's QMB is approved. One cause of delay is that the contract does not place any responsibility for the buy-in on the beneficiary. It simply states that qualified individuals "shall be enrolled" in Medicare Part B. *See id*, Buy-in Agreement, § B. Although the process is supposed to be automatic upon enrollment in QMB, Legal Aid has encountered several people whose Medicare Part B enrollment was delayed due to administrative or technical errors in the enrollment process. These errors can leave people without Part B coverage for many months after their QMB approval, and therefore unable to receive primary medical care. Legal Aid has helped several people in such situations, but for those without access to attorneys or other advocates, the issue might not ever be resolved.

Furthermore, even when the current system works as intended, there is still a two month delay between a person's QMB approval and Part B enrollment. Part B for qualified individuals only begins two months *after* becoming "eligible" under the contract

– *i.e.* two months after receiving QMB benefits. *See id*, Buy-in Agreement § A(9)(a)(ii) (noting that the coverage period for those eligible for Part B buy-in because of their medical assistance begins on the first day of the second month after receiving medical assistance). Therefore, individuals who buy-in to Part B based on their QMB must wait at least two months to access primary health care through Medicare Part B. During this delay, the individual is without access to comprehensive, out-patient health benefits through either Medicaid (because the person is ineligible) or Medicare Part B (because this coverage is delayed). For District residents in this situation, obtaining primary health care through the Alliance program is the only remaining option.

b. DHCF should provide continued Alliance coverage to those who do not automatically qualify for any Medicare.

Some Alliance enrollees will not automatically qualify for any Medicare coverage. For instance, people who do not qualify for Social Security Retirement benefits are not automatically enrolled in Medicare when they turn 65. Such individuals, however, can still buy in to both Part A and Part B. *See* District of Columbia State Plan for Medical Assistance, §3.2(a)(1)(i) (noting that the District has a buy-in agreement for Medicare Part A and Part B); *see also* Attachment 3.2A, Pg. 1, §B (stating that the District will pay Part A premiums for QMBs).

It is unclear whether DHCF would consider these individuals to be "eligible" for Medicare. If so, it is unclear whether DHCF intends to facilitate Medicare buy-ins for Alliance enrollees who do not automatically qualify for Medicare. If DHCF terminates Alliance benefits and does not assist with the buy-in process by working with IMA to enroll people in QMB and buy them into Medicare Part B, many of these individuals will have no idea how to obtain Medicare benefits. If DHCF does plan to facilitate buy-ins for this population, the agency should not terminate Alliance coverage until the person's Medicare Parts A, B and D become effective.

Recommended changes:

1. **Legal Aid recommends that the proposed regulation be amended to read as follows:**

> Eligibility for the D.C. HealthCare Alliance is limited to residents of the District of Columbia who are not eligible for Medicaid, **or are not enrolled in Medicare** or any other third party health insurance program, and who live in households:
>
> a) With a countable income of less than 200 percent of the Federal Poverty Level; and

b) With countable resources less than $ 4,000 (or $6,000 if the individual lives with a spouse or cares for a child who is residing in the home).

This proposed change will clarify that individuals who are "eligible" for Medicare, but not yet covered by all parts of Medicare, will be allowed to continue receiving Alliance benefits until the Medicare buy-in process is complete.[1]

2. Include definition of Medicare in Alliance regulations.

To further clarify that a person will not lose Alliance coverage until he or she has Medicare benefits, Legal Aid proposes adding the following definition to § 22-3399.1 of the Alliance regulations.

Medicare – active enrollment in Medicare Parts A, B and D.

II. DHCF should clarify its definition of Medicaid for the purposes of determining Alliance eligibility so as not to exclude from Alliance coverage individuals with anything but full Medicaid coverage.

a. QMB, without Medicare Part B, should be excluded from the definition of Medicaid.

DHCF should allow people to remain in the Alliance, even after being approved for QMB, until their Medicare enrollment is complete. Although obtaining QMB is an important step in the Medicare buy in process, QMB itself is not health insurance. QMB is defined only as Medicare cost-sharing, and does not provide access to health care until the person's Medicare is also approved and effective. *See* 42 U.S.C. § 1396d(p) (describing the Qualified Medicare Beneficiary program as designed to pay Medicare costs that are normally the responsibility of the beneficiary directly). Historically, however, the District seems to have terminated Alliance coverage when a person's QMB benefits were approved. Such terminations mean the person has no access to primary health benefits while they await Medicare coverage.

b. Emergency Medicaid, which is different from full-scope Medicaid, should be excluded from the definition of Medicaid.

DHCF should also amend the definition of Medicaid to ensure that those who only receive Emergency Medicaid will still be eligible for Alliance coverage. The Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 (PRWORA) placed severe limits on the eligibility of many legal immigrants for public benefits programs, including full-scope Medicaid. *See* 8 U.S.C. § 1611. Immigrants who do not have eligibility for full scope Medicaid due to PRWORA's restrictions can still

[1] Because IMA and DHCF have authority over the District's Medicaid program, as well as the Alliance program, it is assumed that Alliance enrollees who are "eligible" for Medicaid will be transitioned to full Medicaid without any break in coverage.

receive services through Emergency Medicaid in cases of medical emergencies. *See id*, § 1611(b)(1)(A). A medical emergency is narrowly defined as a condition that could reasonably be expected to place the person's health in serious jeopardy, lead to serious impairment to bodily functions, or lead to serious dysfunction of bodily organs or parts. *See* 42 U.S.C. § 1396b(v)(3) (2009).

Without an exclusion of Emergency Medicaid from the Alliance's definition of Medicaid, immigrants who have no other means of obtaining comprehensive, public health insurance will be denied Alliance benefits. Emergency Medicaid does not cover any care beyond that related to these types of medical emergencies. Therefore, an individual whose services are paid for through Emergency Medicaid cannot access the comprehensive health care services that the Alliance program provides. *See id,* § 1396b(v) (2009). For example, one Legal Aid client had a stroke, and his hospitalization was paid for through Emergency Medicaid. However, when he left the hospital, he was denied Alliance benefits for his feeding tube and physical therapy because he was considered "eligible" for Medicaid under the Alliance regulations. We fear that without a rules change other immigrants will find themselves without health coverage for some period of time after an emergency health crisis has been resolved and their ongoing need for care continues.

Recommended changes:

1. Amend Alliance regulation's definition of Medicaid.

Legal Aid recommends that DHCF amend the Alliance regulation's definition of "Medicaid," found at D.C. Code Mun. Regs. § 22-3399.1, to clarify that QMB benefits, without Medicare Part B enrollment and Emergency Medicaid, will not be considered Medicaid for the purposes of determining Alliance eligibility. The current definition of Medicaid reads as follows:

> Medicaid -- a federally funded program that pays for medical care and health services for certain low-income persons. The program was established by and funded pursuant Title XIX and Title XXI of the Social Security Act of 1935, 42 U.S.C. §§ 1396 to 1396u-3 (2005).

Legal Aid recommends amending the definition to read:

> Medicaid -- a federally funded program that pays for medical care and health services for certain low-income persons. The program was established by and funded pursuant Title XIX and Title XXI of the Social Security Act of 1935, 42 U.S.C. §§ 1396 to 1396u-3 (2005). **This definition does not include medical assistance in the form of Qualified Medicare Beneficiary (QMB) coverage, as described at 42 U.S.C. §1396d (p) (2009), unless the individual is also enrolled in Medicare Parts A, B and D. This definition also does not include Emergency Medicaid, as defined in these regulations.**

2. Include definition of Emergency Medicaid in Alliance regulations.

Legal Aid further recommends adding the following definition of Emergency Medicaid to the Alliance regulations:

> Emergency Medicaid – a federally funded program that pays for certain limited medical care and health services for certain aliens. The program was established by and funded pursuant to Title XIX of the social Security Act of 1935, and is described at 42 U.S.C. §1396b(v) (2009).

III. DHCF should define "other 3rd party insurance" to exclude limited insurance benefits that do not provide comprehensive health care services.

Excluding all individuals with any form of "other 3rd party insurance" from Alliance eligibility could mean that people with a very limited insurance benefit are unable to get the comprehensive health services that the Alliance provides. For instance, some job-related medical insurance might only provide access to catastrophic coverage. Someone with such a limited benefit, however, would be unable to access important health services such as primary care, specialty care, hospital services, and others. As the proposed regulation is currently written, individuals with this limited coverage would also be disqualified from receiving Alliance benefits, and might have no other way to access preventative health care benefits.

Excluding those with such limited insurance benefits from Alliance coverage would defeat the purpose of the program, which as noted above is to provide comprehensive health care benefits to District residents without other access to care.

Recommended change:

Legal Aid suggests adding the following definition to the Alliance regulations, found at D.C. Code Mun. Regs. § 22-3399.1:

> Other 3rd Party Insurance – insurance that provides access to comprehensive health care services, including primary care services, specialty care, and inpatient and outpatient hospital services.

Comments and Proposals Related to Implementation -- Transitioning people from Alliance and Medicaid to Medicare will require individualized attention to those individuals' prescription drug needs.

One effect of the proposed policy that could be particularly confusing for affected individuals is the transition into Medicare Part D prescription drug coverage. The generosity of the District's medical assistance program means that both Medicaid and Alliance enrollees have access to comprehensive prescription drug coverage. Those who

are transitioned into Medicare, however, will lose their current drug coverage and will have to receive their drugs through Medicare Part D. *See* 42 U.S.C. §1396u-5(d)(1) (stating that dual eligible individuals must receive their prescription drugs through Medicare rather than Medicaid).[2]

Unlike Medicaid and the Alliance, which both utilize a single drug formulary and a set of restrictions applicable to all enrollees, Medicare Part D consists of multiple plans that each have a unique formulary and set of restrictions. Those who qualify for assistance through the low-income subsidy, as all Medicaid and Alliance recipients should, will be randomly enrolled in one of the various Part D plans unless they select a plan themselves. *See* 42 C.F.R. §423.34(d).

Unfortunately, there is no guaranty that a random Part D plan will cover the particular drugs an individual needs. Recently, Legal Aid assisted two individuals, a married couple, with selecting a Part D plan. They had been enrolled in QMB, with an effective date of March 1, 2009. Through the auto-enrollment process, these individuals were each enrolled in a random drug plan that would not be effective until May 1, 2009. These plans would not have covered multiple drugs that the individuals needed, and would have placed restrictions, such as prior authorizations and step therapies, on other drugs. The annual costs for each client would have been in the thousands of dollars,[3] an amount they could not have afforded. Legal Aid worked with these clients to select a plan that covered their drugs with as few restrictions as possible. Now, each client is enrolled in a plan that with an annual cost of only a few hundred dollars.

The example of these clients illustrates why those transitioned into Medicare from other health coverage will need individualized attention to: 1) their prescription drug needs, and 2) how those needs match up with the various Part D plans. Legal Aid encourages DHCF to develop a process for assisting those who will be affected by the new policy with selecting the Part D drug plan that best meets their needs.

Conclusion

These comments propose ways that the DHCF can responsibly ensure that the Alliance does not provide duplicative coverage for those who have other ways of accessing primary health services yet still make the program available for District residents who truly need its benefits. The Alliance program was designed to provide comprehensive access to health care services to individuals unless and until they have other comprehensive health coverage. Legal Aid supports efforts to enroll eligible residents into Medicaid and Medicare, and take advantage of the Emergency Medicaid program, but it is important that DHCF transition people in a way that will not result in any disruption in access to health coverage.

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[2] This provision of federal law applies only to dually eligible individuals. Of course, when DHCF transitions Alliance enrollees to Medicare, they will also lose their Alliance prescription drug coverage and begin receiving coverage through Medicare Part D.

[3] The clients would have had to pay the full price for any drug not covered under their plans' formularies.

We appreciate the opportunity to submit these comments, and we look forward to continuing to work together on these proposed regulations. We will follow up with your office in the near future, and please do not hesitate to contact us in the meantime if you have any thoughts or questions. You may contact Andrew Patterson at (202) 386-6665 (apatterson@legalaiddc.org) or Jennifer Mezey at (202) 661-5962 (jmezey@legalaiddc.org).

Sincerely,

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