SENIOR HEALTH NEWS

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Volume 10, Issue 4

August 2008

Proposed Assisted Living Regulations Published and Ready for Public Comment!

On August 9th, the Department of Public Welfare published proposed regulations for Assisted Living Facilities. **Public comment is due September 15th** and can be submitted by mail to: Gail Weidman, Office of Long-Term Care Living, Bureau of Policy and Strategic Planning, P. O. Box 2675, Harrisburg, PA 17105, by September 15, 2008. Reference Regulation No. 14-514 when submitting comments.

These are the first regulations specifically for Assisted Living facilities. Until now, assisted living facilities have been lumped together with personal care homes for licensure, despite the more involved care needs of assisted living residents. The regulations build from the personal care home regulations, as their launching point.

Although the proposed regulations do go further than the existing personal care home regulations in some areas, they fall short of what is necessary to provide adequate care to the older adults and persons with disabilities who will live in these types of residences. Examples of areas where the proposed assisted living regulations contain some critical improvements over personal care home regulations include: meaningful and sufficient licensure fees to fund state oversight efforts, resident contracts run month to month allowing the resident to terminate the contract with 14 day notice, air conditioning required in the entire facility, and a nurse required to be on call 24 hours/day.

However, there are several areas that need strengthened in the final regulations. As proposed, a consumer would have to move in, sign a contract for residency and services, and begin payment to the facility weeks before the facility would be required to assess the consumer's care needs, explain to the consumer and her family how those needs would be addressed, and detail how much it would cost. As proposed, direct care staff would not be required to complete a minimum amount of training hours and not all direct care staff would have to be trained in first aid or CPR. As proposed, facilities that exist as of the day the regulations take effect would be exempt from meeting the best available standards or practices for such things as fire safety and wheelchair accessibility.

Other ways in which the proposed regulations fall short include:

- Staffing requirements are inadequate to meet residents' needs;
- Resident living space is too small to allow easy navigation by those with walkers or wheelchairs;

(Continued on Page 2)

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(Continued from Page 1)

- Essential residents' rights are left out;
- Residents have no mechanism to challenge a facility's decision to kick them out;
- Permit the residence to restrict the health care providers residents may use rather than protect a resident's right to continue to use or otherwise choose providers, such as their doctor or psychiatrist;
- Annual instead of quarterly needs assessments and support planning.

It is essential that public comments be submitted that raise both the good and the bad about the proposed regulations. Recognizing the good provisions in the regulations will help ensure that the Department of Public Welfare and the Independent Regulatory Review Commission (IRRC), as well as the general public, know how critical the provisions are so that they are not removed in the final draft. Detailing the bad provisions as well as the crucial missing pieces to the regulations informs the state and general public of those matters that are fundamentally important to consumers and their families.

Comments are due September 15, 2008. The proposed regulations can be viewed at: http://www.pabulletin.com/secure/data/vol38/38-32/index.html. There was a correction issued in the August 16th PA Bulletin because the previous publication failed to include an address for submitting comments (http://www.pabulletin.com/secure/data/vol38/38-33/index.html).

PHLP and the PA Assisted Living Consumer Alliance (PALCA) encourage all interested parties to submit comments to make sure your voices are heard! PALCA's summary of the regulations and comments will be posted on their website soon at: www.paassistedlivingconsumeralliance.org. Position statements on various issues such as Living Units, Informed Consent and Residents Rights, Assessment/Support plan, Staffing and Training, and Public Funding are already posted on the website. Please contact Alissa Halperin for more information at ahalperin@phlp.org.

Public Hearing on Regulations

A Public Hearing on the Proposed Assisted Living Regulations is scheduled for September 18th at 9:30 am. The hearing is being held by the House Health and Human Services Committee in Room 205 of the Ryan Office Building in Harrisburg, PA. This is after the deadline for public comment but during the 30 day period for the Independent Regulatory Review Commission and the General Assembly Standing Committees to produce their comments. Check the PALCA website for more details on how to testify or submit written comments at this hearing.

PALCA Looking for Stories

As you know from previous newsletters, PHLP is leading an alliance of consumers, family members, and advocacy organizations working together to bring about meaningful assisted living regulations for Pennsylvania. We are looking for your stories (good and bad) about personal care homes or assisted living facilities. Real examples help regulators and lawmakers understand the need for concrete solutions. PALCA wants to hear if you, a friend, or a loved one:

- needed services that a facility was not equipped or willing to provide;
- were discharged for running out of money;
- were discharged for needing more care;
- were discharged for complaining about conditions;
- received poor quality care due to lack of staff or staff training;
- were unaware of their rights or afraid of exercising them; or
- have any other personal experience to share.

Share your story at http://www.paassistedlivingconsumeralliance.org/index.php/tell-us-story or by calling Barbara Beck at (215)209-3076.

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New Medicare Law Includes Important Changes for Consumers

On July 15, 2008, Congress overrode a presidential veto of H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008. This law includes many important provisions for Medicare consumers, especially low-income Medicare consumers. Many of the provisions do not go into effect until January 2010, but some of the changes take effect immediately or over the upcoming year.

The new law delays implementation of the Medicare Competitive Bidding Program for durable medical equipment and supplies (see page 4), reduces the co-payment for Medicare-covered mental health services from 50% to 20% over six years (see page 4), extends the Qualified Individual (QI) Medicare Savings Program and increases the asset limit for the program (see page 5), eliminates the Part D late enrollment penalty for people who qualify for the low-income subsidy (LIS) (see page 6), places new requirements on Special Needs Plans (see page 7), and places certain restrictions on Medicare Advantage Plans and Prescription Drug Plans sales and marketing activities (see page 8). The articles on the following pages further explain these important provisions of the law and what they mean for Medicare consumers.

Other important provisions of this law that are not discussed in detail in this newsletter include:

- Extension of the exceptions process for outpatient physical, speech and occupational therapy services through December 31, 2009. In 1997, Congress placed limits on how much Medicare would pay for certain outpatient therapy services. In 2008, the limit is $1810 for outpatient physical and speech therapy (combined) and $1810 for outpatient occupational therapy. The exceptions process can be used when consumers need additional therapy services once the cap is reached.
- Delayed cuts to physician payments.
- Expansion of the timeframe for coverage of a Welcome to Medicare physical from the first 6 months to the first 12 months of Medicare coverage (starting January 1, 2009).
- Coverage under Part D for Barbiturates (used to treat certain conditions such as epilepsy, cancer or chronic mental health disorders) and Benzodiazepines starting in 2013. Currently, medications in these two classes of drugs are excluded from Part D.
- Changes to the criteria for Part D coverage of off-label use of drugs for cancer treatment beginning in 2009.
- Extra funding for State Health Insurance Programs (in PA, the APPRISE program) and Area Agencies on Aging to do outreach.

We'll continue to update you about developments related to this law in future newsletters.

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Medicare Durable Medical Equipment Competitive Bidding Program in Western Pennsylvania Delayed

The Medicare Improvements for Patients and Providers Act of 2008 delayed the implementation of Medicare's Durable Medical Equipment (DME) Competitive Bidding Program for 18 months. We reported on this Program in the June Senior Health News. The Competitive Bidding Program began on July 1st and was being piloted in 10 areas of the country, including the Pittsburgh area, for certain equipment and supplies covered by Medicare (i.e., oxygen and supplies, power wheelchairs and scooters, walkers and hospital beds). However, the program is now delayed as of July 15, 2008 when Congress overrode a presidential veto and passed the law.

As a result of this delay, traditional Medicare beneficiaries in the Pittsburgh CBA can again use **any** Medicare-approved supplier for their medical equipment and supplies. If a beneficiary changed suppliers when the Program started on July 1st, he can continue to use the new supplier, go back to his old supplier, or choose another Medicare-approved supplier. The original DME payment rates to suppliers in effect prior to July 1st are reinstated retroactively.

All Medicare beneficiaries in the Pittsburgh CBA should have received information from Medicare about the Program's delay. If you or your clients have any questions or problems resulting from the start, and then stop, of the Competitive Bidding Program, please contact our Helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

Medicare Beneficiaries to Pay Less for Mental Health Services

Consumers of mental health services scored a victory last month when Congress overrode President Bush's veto and enacted the Medicare Improvements for Patients and Providers Act of 2008. Under the Act, Medicare beneficiaries will see decreases in their co-pays for outpatient mental health services over the next 6 years.

Currently, Medicare beneficiaries are responsible for a 50% co-pay for covered outpatient mental health services. Starting in 2010, co-pays for mental health services will be reduced to 45% and then will continue to reduce as follows: 40% in 2012, 35% in 2013, and finally to 20% in 2014.

By 2014, Medicare beneficiaries will have the same co-pays for outpatient mental health services as they have always had for outpatient physical health services covered by Medicare. Since the inception of the Medicare program in 1965, Medicare paid 80% of the cost for outpatient physical health services but only 50% of the cost for outpatient mental health services.

National organizations including Mental Health America and NAMI applauded Congress for passing legislation to improve Medicare benefits for persons with mental illness. Many advocates agree that this law is a significant step toward decreasing stigma against mental health illnesses and increasing access to mental health services for Medicare beneficiaries.

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Changes to the Medicare Savings Programs Under the New Medicare Law

The Medicare Improvements for Patients and Providers Act of 2008 recently passed by Congress contains some important provisions that should significantly increase consumer access to the Medicare Savings Programs (a/k/a "Medicare Buy-In"). These programs allow Medical Assistance to pay the Medicare Part B monthly premium for certain low-income Medicare beneficiaries.

Extension of the QI-1 program

QI-1 refers to one of the Medicare Savings Programs. It provides payment of the Part B premium for Medicare beneficiaries who have limited resources and whose income is between 120% and 135% of the federal poverty level (currently $1040-$1170/month for a single individual). This program was set to expire on June 31, 2008. Instead, under the Act, Congress extended the program until December 31, 2009.

Raising the Asset Limit for the Medicare Savings Programs

In addition to being low income, persons eligible for the Medicare Savings Programs must also have limited assets. The current asset test is $4,000 for a single person and $6,000 for a married couple. Under the Medicare Improvements Act, **effective January 1st, 2010** the asset limit for the Medicare Savings Programs will increase to be the same as the asset test for a full Low Income Subsidy (LIS) under Medicare Part D. The full LIS asset limit (which increases annually) is currently $6,290 for a single person/$9,440 for a married couple. It is important to remember that anyone who is eligible for one of the Medicare Savings Programs is automatically eligible for a full LIS and does not need to apply for it!

Improved information-Sharing and Coordination Between Social Security and Medical Assistance

The Medicare Improvements Act also contains important provisions aimed at better coordination between the Medicare Part D Low Income Subsidy Program (operated by Social Security Administration) and the Medicare Savings Programs (operated by State Medicaid programs). Under the Act, **effective January 1, 2010**, Social Security is required to:

- Coordinate outreach activities in connection with the LIS and the Medicare Savings Programs;
- Train SSA personnel who handle LIS applications about the Medicare Savings Programs so that they can better assist beneficiaries in accessing those programs;
- Provide information on the Medicare Savings Programs to all LIS applicants and anyone who is identified as potentially LIS eligible;
- Transmit data from the LIS application (with the applicant's permission) to the state Medicaid agency for the purposes of initiating an Medicare Savings Program application; and
- Provide information on how the person can obtain assistance with completing the Medicare Savings Program application, including how to contact their State's Health Insurance Assistance Program (in PA, this is called the APPRISE program).

When a State Medicaid Agency receives the data transmitted from SSA, the State is to act on the information in the same way, and with the same deadlines, as it would treat an MSP application received directly from a consumer. In addition, the date of the MSP application shall be the date the individual applied for the LIS with the Social Security Administration.

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Coming Soon: Improvements to Part D Low Income Subsidy Program

Several important changes to the Medicare Part D Low Income Subsidy (LIS) Program were contained in the Medicare Improvements for Patients and Providers Act. The LIS is a Medicare Program that allows low-income beneficiaries to qualify for extra help paying for the costs associated with enrolling into Medicare Part D Prescription Drug Plans.

Elimination of the Part D Late Enrollment Penalty for LIS Eligibles

In order to encourage as many beneficiaries as possible to enroll into a Medicare Part D plan as soon as they are Medicare eligible, the law that established Part D contains a "late enrollment penalty". If a beneficiary does not already have creditable coverage (prescription benefits at least as good as Part D), and does not join a Part D Plan during their Initial Enrollment Period, she may have to pay a penalty for delaying her enrollment if she later decides she wants the Part D benefit. The penalty is a 1% increase in her Part D plan premium for every month she delayed her enrollment. Under the new law, **effective January 1, 2009**, no person who is determined eligible for a LIS shall be subject to any Part D late enrollment penalty.

Counting Life Insurance As An Asset

To qualify for an LIS, individuals must meet an income and an asset test. Currently, a single individual can have no more than $11,990 in assets; a married couple no more than $23,970 in assets to be eligible for an LIS. If the LIS applicant has life insurance with a face value greater than $1500, the cash value of the policy(ies) must be reported and is counted as an asset. Under the new Medicare Improvements Law however, no part of the value of any life insurance policy will be counted as an asset for any LIS applications filed **on or after January 1, 2010**.

Appealing LIS Eligibility Determinations

If an individual applies for an LIS with the Social Security Administration and the person receives an unfavorable determination, that determination can be appealed and the person given a hearing by the Social Security Administration. Previously, however, the hearing decision was considered the final decision of the Commissioner of Social Security and the individual had no further avenues of appeal if they disagreed with SSA's hearing decision. Under the new Medicare law, effective immediately, beneficiaries now have the right to judicial review. That is, anyone who disagrees with the SSA's hearing decision regarding their LIS eligibility can appeal that determination to the Federal District Court.

Are you an advocate or provider working with dual eligible clients over 60 years old in Southeastern PA who wants to stay up to date on Part D developments? Join the PHLP e-mail list serve! To join, e-mail staff@phlp.org with subject "join Part D list serve".

PHLP staff are also available in SE PA to conduct trainings on Part D related issues to help social service agencies and their dual eligible clients navigate their healthcare coverage. Trainings focus on eligibility for Medicare Savings Programs and the Low-Income Subsidy, healthcare access for dual eligibles, rights of dual eligibles under Part D, and the appeals and grievance processes. Contact the PHLP Helpline to schedule a training at 1-800-274-3258 or 1-866-236-6310/TTY.

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New Medicare Law's Impact on Special Needs Plans

Starting in 2010, Medicare Special Needs Plans (SNPs) will have to meet some new requirements aimed at addressing concerns about these Plans raised in recent years by PHLP and other advocates. Even though these changes don't take place immediately, we wanted to notify you of changes that will be coming in the future. Medicare Special Needs Plans were created under the Medicare Modernization Act of 2003. Special Needs Plans are approved to provide coverage to a limited population of beneficiaries such as people in institutions (i.e., nursing homes), dual eligibles (people with both Medicare and Medical Assistance), and those with certain chronic conditions (i.e., heart disease or diabetes). This year in PA, there are 3 SNPs for institutionalized individuals, 14 SNPs for dual eligibles, and 10 SNPs for individuals with certain chronic conditions.

The new law extends the authority for Medicare Special Needs Plans through December 31, 2010. Currently, there is a moratorium on new Special Needs Plans which means Medicare cannot approve any new Plans and current SNPs cannot expand the areas where they offer coverage. This moratorium will end January 1, 2010 per the new Medicare law.

SNPs will have to meet new care management requirements including completing an initial and yearly assessment to identify needs of each enrollee in certain areas and developing a plan to meet the needs of each enrollee (with consumer involvement in this process). The care management team will have to be interdisciplinary and will have to follow a model of care with appropriate networks of providers and specialists. All SNPs will be required to collect and report data to Medicare that measures quality and health outcomes.

Dual eligible SNPs will be required to have arrangements with the Department of Public Welfare to verify an individual's dual eligible status immediately. The law requires any new dual SNP in 2010 and thereafter to have contracts with the state to provide or arrange for Medical Assistance benefits; however, the law does not require states to contract with SNPs. Dual eligible SNPs also will be prohibited from charging higher cost-sharing than the Original Medicare program. Institutional SNPs will be required to enroll individuals living in the community who require an institutional level of care. This means that individuals in the Medicaid Home and Community Based Services Waiver programs will be able to enroll in Institutional SNPs after January 1, 2010. There will also be new criteria for qualifying to enroll in a SNP for individuals with chronic conditions.

We will continue to update you on these issues, especially those related to dual eligible SNPs as developments occur and as more details become available about what these changes mean for Pennsylvanians.

PHLP Welcomes A New Staff Attorney

PHLP welcomes Kyle Fisher who will be a new staff attorney in our Philadelphia Office starting September 2nd. Kyle is joining PHLP under a fellowship from the Skadden Fellowship Foundation. He will be providing direct representation to low-income veterans in the Philadelphia metropolitan area as they navigate the VA system, and in informal and formal appeals. Kyle will also be providing trainings on health care appeals to veteran service organizations in the Philadelphia area.

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New Limits on Marketing and Sales of Medicare Plans

Starting in the Fall when Medicare Advantage (managed care) Plans and Medicare Prescription Drug Plans begin to market their 2009 plans, they will no longer be able to use certain marketing and sales practices that have caused problems for beneficiaries over the past years. The Medicare Improvements for Patient and Providers Act of 2008 prohibits plans from the following sales and marketing activities:

- Cold calling consumers and door-to-door marketing and sales;
- Selling non-health products (i.e., life insurance or annuities) during meetings or presentations about Medicare plans;
- Providing free meals at promotional events;
- Selling or marketing plans in health care settings like doctor's offices and pharmacies.

The law also limits the commission agents and brokers can receive, limits gifts that plans and agents/brokers can offer potential enrollees, requires that beneficiaries and agents/brokers agree to the scope of a marketing meeting in advance, and requires training and testing of agents and brokers. Plans are required to use agents/brokers licensed under state law and comply with certain reporting requirements and information requests. Many of these provisions will be in effect for the upcoming Part D Open Enrollment Period (beginning November 15, 2008) and all of these changes will be effective starting January 1, 2009.

Consumer advocates applaud these marketing limitations and hope the changes will eliminate unscrupulous sales practices that have taken advantage of vulnerable consumers and resulted in them being enrolled in plans they did not want.

CMS Issues Memo To Help Ensure that Dual Eligibles Pay Right Co-pay

Earlier this month, the Centers for Medicare & Medicaid Services (CMS) released a memo to all Medicare Part D Plans clarifying the Best Available Evidence Policy and announcing a new process Plans must follow when a dual eligible (someone with both Medicare and Medical Assistance coverage) cannot document their dual status or their eligibility for the low-income subsidy.

The Best Available Evidence Policy requires Part D plans to accept certain documentation as proof of eligibility for the low-income subsidy (i.e., an award letter from the Social Security Administration or a Medicaid eligibility notice) or proof of institutional status resulting in zero cost-sharing. Though this policy has been in place since the end of 2006, consumers and advocates have had ongoing problems getting Plans to lower a consumer's co-pays or update their systems in a timely fashion.

The new memo issued on August 4, 2008 clarifies that Plans **must** accept certain documentation as proof of subsidy eligibility from the consumer or someone acting on her behalf (i.e., a pharmacist, advocate, family member) and that the Plan **must** provide the consumer with medication at the reduced co-pay amount **as soon as it receives the documentation**. Plans then have 3 days (72 hours) to update their system to show the correct low-income subsidy (LIS) cost-sharing amount. If the CMS system does not show the correct LIS co-pay, the Plan must notify CMS of the LIS and request that their system be corrected.

In addition to these clarifications, the memo also describes a new process for situations where a dual eligible cannot provide proof of their dual status or eligibility for the low-income subsidy. Remember, all dual eligibles automatically qual-

(Continued on Page 9)

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(Continued from Page 8)
-ify for the full low-income subsidy. In this case, the plan must find out how soon the beneficiary will be out of medications. Within one business day, the plan must notify the CMS Regional Office that an individual claims to be eligible for LIS but cannot provide proof. The Plan must let CMS know whether immediate help is needed or not (based on when the consumer will be out of medications in less than 3 days). The Regional Office will then contact the Department of Public Welfare to verify a consumer's dual eligible status. Once the Plan hears back from CMS, they must update their systems and contact the consumer or their representative. The Regional Office will be monitoring Plans to make sure they follow these requirements and that they have a special complaint tracking process specifically for issues related to this policy.

The memo was effective immediately upon its release and is a direct result of the settlement agreement in the nationwide class action lawsuit, *Situ vs. Leavitt*, that was preliminarily approved last month and discussed in our June *Senior Health News*. Please contact PHLP's Helpline at 1-800-274-3258 or 1-866-236-6310 (TTY) if you have questions or need assistance with having your LIS status updated per this new memo.

Alert for Waiver Applicants and Recipients!

As we have discussed in previous editions of this newsletter, there have been ongoing problems with the state's Nursing Facility Clinically Eligible (NFCE) standard that individuals have to meet to qualify for many of the state's waiver programs. Essentially, the state required that individuals have skilled care needs in order to be considered NFCE despite the fact that the federal law allows someone to be NFCE if they have **intermediate or** skilled needs.

The state has issued a new definition of NFCE effective July 1st that appears to allow individuals with intermediate care needs to be NFCE. They have issued a draft bulletin containing the new definition and have trained 1,700 assessors on the new definition. However, advocates are concerned that changes could be made before the bulletin becomes final (the draft bulletin is in the process of being approved) and because the training materials do not provide any examples of consumers with intermediate care needs who would meet the NFCE definition.

Nonetheless, a legal services attorney did report success in one recent case where she received a favorable decision based on the new definition of NFCE. In this case, a client with intermediate care needs was determined to not be NFCE after an assessment by the Area Agency on Aging (AAA) was done and therefore was told she did not qualify for the Aging waiver. The client requested a Fair Hearing. The hearing ended up being cancelled because AAA staff notified the legal services attorney that, based on the new NFCE definition, the client did meet the standard and was now eligible for the Aging waiver.

If you were recently terminated from, or denied eligibility for, the Aging, Attendant Care, Independence, or COMMCARE Home and Community Based Services Waiver Programs, contact PHLP immediately for free legal advice and possible representation on appeal. We want to be sure that people are aware of the new definition and ensure that the standard is being applied properly. Please contact our HELPLINE (1-800-274-3258 or 1-866-236-6310/TTY) for more information or if you need assistance with the appeal process.

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Renewal of the Aging and Attendant Care Waivers

As we have previously reported in the February and April/May editions of the Senior Health News, Pennsylvania's Aging Waiver and Attendant Care Waiver expired at the end of June 2008. The Office of Long-Term Living submitted waiver renewal requests to the Centers for Medicare & Medicaid Services (CMS) earlier this year, but CMS has not yet approved those requests. Instead, CMS extended the current waivers for 90 days (until the end of September) while the state continues to work to address concerns raised by CMS. In order for CMS to approve the waiver renewals, they want the state to address certain areas such as Administrative Oversight, Quality Assurance, and Rate Setting.

At this time, individuals who are currently in these two waivers continue to get services and existing waiver slots can be filled with new applicants. However, no new waiver slots can be created until the renewal requests are approved by CMS. We will provide further updates in the next edition of our newsletter. Please contact our HELPLINE at 1-800-274-3258 or 1-866-236-6310 (TTY) with further questions about this issue or if you are having problems getting services under either of these two waivers.

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