



SENIOR HEALTH NEWS



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Helping Low-Income Medicare Beneficiaries Facing Plan Terminations At The End Of The Year

Thousands of full dual eligible individuals are currently in Medicare Special Needs Plans* (SNPs) that will no longer offer coverage after December 31, 2009. The Medicare SNPs that are ending have notified affected members by mailing letters that describe the choices individuals have for their health care coverage in 2010. These letters are generic letters sent to any Medicare beneficiary whose Medicare Advantage plan is terminating. The letters are not written in a consumer-friendly way and they include information that is not relevant to the dual eligible population. For this reason, we wanted to make sure consumers and professionals working with them understand their options for coverage in 2010.

**Medicare SNPs are Medicare Advantage plans whose enrollment is limited to certain groups of Medicare beneficiaries such as those with both Medicare and full Medical Assistance coverage, individuals who are institutionalized, or individuals who have certain chronic health conditions.*

Medicare dual eligible SNPs terminating after 12/31/2009:

- **Advantra One** (operates currently in various counties across the state)
- **Aetna Golden Medicare Dual Advantage** (operates currently in certain counties in Eastern PA)
- **Keystone 65 Complete** (operates currently in Southeastern PA; see our August SHN for further details about this plan's termination)
- **Evercare Plan DP** (operates currently in certain counties in Southeastern PA)

Choices for Full Dual Eligibles (individuals who have Medicare and full Medical Assistance coverage through the ACCESS card)

- 1) **Move to Original Medicare**-People can choose to receive their Medicare Part A and B coverage through Original Medicare (using their red, white and blue Medicare card) and get their prescription drug coverage through a Medicare Part D Prescription Drug Plan (PDP). If someone chooses this option, she should enroll into a Medicare Part D prescription drug plan before the end of the year so that she has that coverage starting January 1, 2010. If possible, she should enroll into one of the Part D "zero premium plans" available in 2010 (visit www.phlp.org for a listing of the 11 zero-premium plans available in 2010). Enrolling into a PDP will automatically switch someone back to Original Medicare.

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Individuals who choose this option for their coverage in 2010 will use both their Medicare card and their ACCESS card to obtain physical and mental health care. The ACCESS card will cover any Medicare deductibles or co-pays for health care services they receive. These individuals will use their PDP card at the pharmacy to cover their prescriptions.

- 2. Enroll into another Special Needs Plan for dual eligibles** (if one is available in the county where the individual lives)-If there are other Special Needs Plans for dual eligibles available in their county, then individuals can join one of those plans. For coverage to be effective on January 1, 2010, enrollment must occur by the end of December. If the dual eligible consumer joins another Special Needs Plan for 2010 coverage, then he will use both his Special Needs Plan card and his ACCESS card to get physical and mental health care in 2010. The Special Needs Plan will also provide the consumer with Medicare Part D prescription coverage.

Caution!! Before individuals enroll into another Medicare Special Needs Plan, they should check to make sure that the new plan will cover their doctors, specialists, hospital, and other important medical providers. Also, these individuals should check to make sure that the Medicare Special Needs Plan will cover all of the medications they are currently taking.

The letter sent to dual eligibles in plans that are terminating at the end of the year (mailed in October) also described other options like enrolling into Medicare Advantage Plans (other than a Special Needs Plan) or enrolling into a Medicare Supplement (Medigap) plan. Neither option is a good choice for dual eligibles because they already have comprehensive health coverage through Medicare and the ACCESS card, and because they would typically be charged a monthly premium under those options for coverage they do not need.

If full dual eligibles fail to act by the end of the year, they will be automatically moved into Original Medicare starting January 1, 2010. In addition, Medicare will randomly assign the individual to a Part D “zero premium” plan for his/her prescription coverage beginning 1/1/2010. *Remember* that if the Part D prescription plan someone is assigned to does not cover her drugs or meet her needs, *she can change her Part D Plan at any time!*

Choices for Other Dual Eligibles or Non-Dual Eligible Medicare Beneficiaries whose Medicare Advantage Plan is terminating

There are a number of Medicare Advantage plans (non-SNPs) terminating at the end of this year, too. Individuals enrolled in these plans should have also received a letter from their plan telling them of the termination and outlining their options for coverage next year. Individuals should keep in mind the following points.

Other Dual Eligibles and Non-Dual Eligible Medicare Beneficiaries with the Low-Income Subsidy (LIS)-Because these individuals do not have full coverage through Medical Assistance and therefore may not have other secondary health insurance, their options are:

- **Go back to Original Medicare and enroll in a stand-alone Medicare Prescription Drug plan**-If individuals choose this option, they should also strongly consider buying a Medicare supplemental policy (also called a Medigap policy) to provide secondary coverage to their Original Medicare. Individuals whose Medicare Advantage plan is terminating

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have a guaranteed right to purchase a Medicare Supplemental policy. Individuals who choose this option but who do not buy a Medicare supplement (and who do not have an other secondary coverage) will be responsible for the Medicare Part A and B deductibles and co-pays.

- **Join another Medicare Advantage Plan with Part D coverage in their area**—Individuals should be sure to join a plan that will allow them to continue to see their doctors, specialists and other health care providers and that will cover their medications and work at their pharmacy.

Other dual eligibles and other Medicare beneficiaries with the LIS who fail to act by December 31, 2009 will have Original Medicare starting 1/1/2010 but will not be enrolled into a stand-alone drug plan by Medicare until March 2010. These individuals should be able to use the back-up Point of Service process at the pharmacy that is available to dual eligibles and others with a low-income subsidy should they find themselves without drug coverage in January 2010. We will provide more information about the Point of Service process available in 2010 in our December SHN.

Non-Dual Medicare Beneficiaries with no LIS—Individuals who do not get any help from Medical Assistance and who do not qualify for any LIS need to act by December 31, 2009 in order to make sure they have prescription coverage in January 2010. These individuals have the same options as “other dual eligibles” outlined above. However, please note that if a Medicare beneficiary is not a dual eligible and is not someone who qualifies for the low-income subsidy, he/she will not be assigned to a Medicare prescription drug plan. Unless these individuals take action and join a PDP or a Medicare Advantage Prescription Drug Plan by 12/31/09, they will only have Original Medicare coverage starting 1/1/2010. These individuals could then find themselves unable to enroll into a Medicare Part D Plan next year.

All Medicare beneficiaries can find out more about their plan choices at the following sources:

- Medicare & You 2010 Handbook
- www.medicare.gov
- Call APPRISE at 1-800-783-7067
- Call Medicare at 1-800-633-4227 (telephone) or 1-877-486-2048 (TTY)

Individuals can enroll in a Medicare Prescription Drug Plan or a Medicare Advantage Plan (or SNP) in any of the following three ways:

- Contact the Plan directly that you want to join (the phone numbers for all Medicare Advantage Plans and stand-alone Prescription Drug Plans can be found in the Medicare & You 2010 Handbook); or
- Call Medicare at 1-800-633-4227 for help in selecting and enrolling into a Plan; or
- Enroll into a Plan on-line through the Medicare website at www.medicare.gov.

Dual eligibles and other low-income individuals who have further questions or want more information about their 2010 Medicare plan choices can call the PA Health Law Project HELPLINE at 1-800-274-3258 or 1-866-236-6310 (TTY).

Medicare Part D Low-Income Subsidy Eligibility Guidelines Expanding Starting January 2010

The Medicare Improvements for Patients and Providers Act of 2008 (“MIPPA”) made changes to the rules regarding who is eligible for the Part D Low Income Subsidy (a/k/a “Extra Help”) so that more Medicare beneficiaries can take advantage of the program. These changes go into effect on January 1, 2010.

The Low-Income Subsidy Program (LIS) was created to help low-income Medicare beneficiaries pay for the costs of the Medicare Part D Prescription Drug Program. To qualify for an LIS in 2009, a single person must have countable income less than \$1,354/month (150% FPL) and countable assets less than \$11,010; a married couple living together must have countable income less than \$1,821/month and countable assets less than \$22,010. In addition to receiving substantial assistance with their Medicare Part D premium, deductible, and co-pays, anyone who qualifies for an LIS:

- is not subject to the Part D donut hole (the coverage gap during which the person must pay the full price of their drugs);
- qualifies for an ongoing Special Enrollment Period which allows them to enroll in and/or change Part D Plans at any time during the year; and
- is not subject to the late-enrollment penalty if they delayed their enrollment into a Part D Plan.

All dual eligibles (those on Medicare who get any help from Medical Assistance) automatically qualify for a full LIS without needing to apply. All other beneficiaries must complete an LIS application and submit it to the Social Security Administration who determines LIS eligibility.

The MIPPA provisions that go into effect on January 1st change what’s counted as an asset to qualify for the LIS, change what’s counted as income under LIS, and create a new process for sharing LIS data to facilitate enrollment into the Medicare Savings Programs (also known as the Medicare Buy-In programs or, more specifically, QMB, SLMB and QI-1).

Counting Assets Under LIS

When determining eligibility for the LIS, the Social Security Administration does not count:

- the applicant’s primary residence;
- all motor vehicles;
- burial plots and irrevocable burial accounts; and
- up to \$1500 each for the applicant and their spouse unless they indicate on the application that they do not expect to use some of their assets to meet funeral/burial expenses.

Social Security **does count** any real property that is not the applicant’s primary residence as well as any liquid asset (stocks, bonds, retirement accounts, annuities, etc) *that can be converted to cash within 20 days.*

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

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Social Security will update the LIS application for 2010 and the new application will no longer ask questions about life insurance.

Counting Income Under LIS

Applicants must report income from all sources when applying for an LIS. However, not all the income will count. Social Security will disregard the first \$20/month of the applicant's total unearned income (i.e., Social Security, VA benefits, pensions, etc). In addition, if the applicant or their spouse receives earned income (i.e., wages, self-employment income), Social Security will disregard the first \$65/month of that income and ½ of the remaining earned income.

Currently, if the applicant receives any "in-kind support and maintenance" it is counted as income for the LIS. "In-kind support and maintenance" includes help received on a regular basis to pay for food, housing, utilities, and/or property taxes. It does not include help received from a government program (for example, LIHEAP, foodstamps) or from a social service agency (Meals on Wheels, foodbanks, etc). **Beginning January 1, 2010, in-kind support and maintenance will no longer count as income when determining eligibility for the LIS!** The updated LIS application for 2010 will no longer ask questions about the receipt of in-kind support and maintenance.

Using LIS Data to Facilitate Enrollment into the Medicare Savings Programs

MIPPA also creates a new process of data-sharing between Social Security and the state Department of Public Welfare (DPW) to help facilitate enrollment into the Medicare Savings Programs (MSPs). Currently, being found eligible for the LIS does not assist the individual with being found eligible for an MSP. Anyone who applies for an LIS and is approved must contact DPW on their own and complete an MSP application to be considered for that program. This will change next year. Effective January 1, 2010, Social Security will begin to share data with the Department of Public Welfare to assist consumers who may be eligible for the Medicare Savings Programs.

Once Social Security has verified financial information about an LIS applicant and determined eligibility for the LIS, Social Security will then send the data it has on that consumer to the PA Department of Welfare (unless the consumer indicates on the LIS application that they **do not** want their data sent to DPW). DPW will accept that data and send it on to the appropriate County Assistance Office. The CAO is required to act on the receipt of that data as if it were an application for MSP and go on to gather any additional information it may need in order to determine whether or not the person is eligible for an MSP (more information on how the CAO will handle this LIS data is found in the following article about MSP expansion).

If you are working with Medicare beneficiaries who may not be eligible for an LIS under the current rules, but who appear to be eligible under the new MIPPA rules, encourage those consumers to apply for an LIS after January 1, 2010 when the new rules go into effect. For questions or more information about expanding LIS eligibility under MIPPA, please call our Helpline at 1-800-274-3258. If consumers need assistance with the LIS applications, they should contact the APPRISE program (1-800-783-7067) as they have received funding from the federal government to do LIS outreach and enrollment.

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

MIPPA Changes Will Help More People Qualify For The Medicare Savings Programs In 2010

The Medicare Improvements for Patients & Providers Act of 2008 (“MIPPA”) made changes that will expand who is eligible for the Medicare Savings Programs (also known as the “Medicare Buy-In” and hereinafter referred to as “MSP”) and facilitate applications for the MSP. These new MSP rules go into effect on January 1, 2010.

The MSPs are programs in which the Pennsylvania Medical Assistance system pays the Medicare Part B premium for low-income Medicare beneficiaries who qualify. Any Medicare beneficiary can qualify for an MSP as long as they are eligible for Medicare Part B, have countable resources within the allowable limits (in 2009, \$4,000 for a single person/\$6,000 for a married couple) and have countable income within the program guidelines. There are three MSPs and which one a consumer qualifies for depends on their income:

- The **Qualified Medicare Beneficiary Program (QMB)** is for those with income less than 100% FPL (\$903/mo if single; \$1,215/mo if married). Anyone approved for QMB is eligible for payment of their Part B premium as well as an ACCESS card to cover their Medicare deductibles and co-pays;
- The **Specified Low-Income Medicare Beneficiary Program (SLMB)** is for those with income between 100%-120% FPL (\$903-\$1,083/mo if single; \$1,215-\$1,457/mo if married). Anyone approved for SLMB is only eligible for payment of their Part B premium.
- The **Qualified Individual Program (QI-1)** is for those with income between 120-135% FPL (\$1,083-\$1,219/mo if single; \$1,457-\$1,640/mo if married). The **QI-1** program only pays the individual’s Part B premium

Medicare beneficiaries can apply for an MSP in one of two ways: either complete a written application (PA-600M) and send it to their local County Assistance Office (CAO); or apply online through the state’s website at www.compass.state.pa.us. Applicants must send documentation to the CAO verifying their income, assets, etc. The CAO will then decide if the applicant qualifies for an MSP. Those who qualify for the QMB program are entitled to benefits beginning the month they are determined eligible. Those who qualify for the SLMB or QI-1 program get benefits starting the month their eligibility is determined and may also qualify for up to three months of retroactive benefits if they met the eligibility criteria in those previous months.

In addition to getting help with their Medicare Part B premium costs, anyone approved for an MSP is considered to be a “dual eligible” (someone on Medicare who also gets help from Medical Assistance) and therefore:

- is automatically entitled to a full Low Income Subsidy from Medicare (without needing to apply) that will cover most of the costs of their Medicare Part D Prescription Plan;
- will be auto-enrolled into a Part D Plan by Medicare if they have not yet joined a Part D plan on their own;
- is entitled to an ongoing Special Enrollment Period which allows them to initially enroll into a Medicare Part D Plan, or change their Part D Plan, at any time during the year.

Increasing the MSP Asset Limit

In 2009, to be eligible for any of the MSPs an applicant must meet the current asset limits which are \$4,000 for a single person and \$6,000 for a married couple. Effective January 1, 2010 the asset limit for the MSP increases so that it is the same as the asset limit for the full Low-Income Subsidy (LIS)!

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The current asset limits for a full LIS are \$6,600 for a single person and \$9,910 for a married couple. The LIS asset limits for 2010 will be announced by Social Security in December.

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

- When counting assets, the LIS program automatically disregards \$1500 for an LIS applicant and \$1500 for their spouse unless they indicate on the application that they do not plan on using any of their assets to pay for funeral and/or burial expenses. The MSP does not allow this disregard. The only funeral/burial assets the MSP does not count are burial plots and funds set aside in an irrevocable prepaid burial account.
- The LIS program will no longer count life insurance as an asset for the applicant or their spouse starting January 1, 2010. However, the MSP program will continue to count life insurance as an asset. If the total face value of the applicant's life insurance policies is greater than \$1500, then the MSP program will verify the current cash surrender value of the policies and will count any cash surrender value over and above \$1,000 as an asset.

Facilitating Enrollment Into the MSP

As we noted in the previous article, MIPPA creates a new process of data-sharing between Social Security and the PA Department of Welfare to help LIS eligible persons enroll into the MSP. Currently, the only way a Medicare beneficiary can be considered for the MSP is to complete and submit an application to the County Assistance Office (either by mailing in a paper application or applying online). Beginning January 1, 2010, however, submitting an application to Social Security for an LIS will facilitate an application to the CAO to determine if the consumer is eligible for an MSP (as long as the consumer does not indicate on the LIS application that they do not want Social Security to send their information to DPW).

Once Social Security acts on the LIS application and determines the applicant's LIS eligibility, they will send all the information they have on the applicant to DPW. DPW will then forward the information to the appropriate CAO depending on where the applicant lives. The CAO will act on the information as though it were an application for the MSP and consider the date of application to be the date the person applied for the LIS. The CAO will not require the consumer to complete an MSP application in this case. Instead, the CAO will send out a Data Collection Sheet to the consumer seeking any addition information/verifications needed beyond the data sent by Social Security to determine MSP eligibility. If the consumer responds in a timely manner and sends in the requested information, the CAO will go on to determine whether or not the person qualifies for an MSP. If the consumer does not respond to the CAO's request within the time period provided, the MSP application will be denied. Consumers can appeal this denial and seek a Fair Hearing just as with any other DPW decision.*

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

Contact PHLP's HELPLINE with questions about the changes to the MSP eligibility criteria starting in 2010. Consumers needing help with MSP applications should contact APPRISE at 1-800-783-7067.

Medicare 2010-Costs

The Medicare Part D Open Enrollment Period (Nov 15th-Dec 31st) starts in just a few weeks. Everyone on Medicare should review their plan (whether it's a stand-alone Prescription Drug Plan or a Medicare Advantage Prescription Drug Plan) and decide whether to stay with their current plan or to change plans. Individuals should review their plan's coverage and costs for 2010. Individuals who wish to change their plan for 2010 will need to take action by December 31, 2009 and enroll into the new plan they wish to join. Remember, enrolling in a new plan will automatically disenroll someone from their current plan.

The Center for Medicare & Medicaid Services (CMS) recently announced the changes to Medicare premiums, deductibles and co-pays that will go into effect January 1, 2010.

Medicare Part A

Part A covers inpatient hospital care, care in a skilled nursing facility (up to 100 days), some home health care, and hospice services. In 2010, the Part A hospital deductible will be \$1,100 (up from \$1,068 in 2009). If someone is in the hospital longer than 60 days, their cost-sharing in 2010 will be:

- \$275/day for 61-90 days (up from \$267/day in 2009)
- \$550/day for 90-150 days (up from \$534/day in 2009)

Medicare beneficiaries who are in a skilled nursing facility for more than 20 days in 2010 will pay \$137.50/day for days 21 through 100 (compared to \$133.50 in 2009).

Medicare Part B

Part B covers physician's services, outpatient hospital services, ambulance services, durable medical equipment and some home health services. For most individuals, the Part B premium will be the same \$96.40 per month that it was in 2009. All individuals who currently have their Part B premium automatically withheld from their Social Security check and who have

income of \$85,000 or less (\$170,000 or less for married couples) will have the same Part B premium as in 2009. If a current Medicare beneficiary pays their premium directly to Medicare (i.e., its not withheld from their Social Security check) or if someone is a new Medicare beneficiary in 2010, then their monthly premium will be \$110.50. Individuals with income over \$85,000/year (\$170,000/year for married couples) will pay an even higher premium for Part B in 2010 depending on their income.

The Part B **annual deductible** is also increasing to \$155 in 2010 (up from \$135 in 2009).

Medicare Part D

Part D costs differ from Plan to Plan. The monthly premiums of stand-alone Part D Plans in 2010 range from \$16.70 to \$110.70 per month. The "benchmark premium" for Part D plans in Pennsylvania is \$32.09 (the "benchmark premium" is the maximum amount of premium the LIS will pay for someone awarded a full subsidy and in a standard Part D plan).

In addition to their Plan's premium, consumers who do not qualify for a Low Income Subsidy will pay the following costs for a Standard Part D Plan in 2010:

- An annual deductible of **\$310** (up from \$295 in 2009);
- During the initial coverage period consumers pay a 25% co-pay for each medication until total drug costs reach **\$2830** (\$2700 in 2009);
- During the coverage gap (referred to as the "donut hole") consumers pay 100% of their drug costs until their total out-of-pocket expenses reach **\$4550** (\$4350 in 2009); and
- During the catastrophic coverage period, consumers will pay co-pays for their medications of either \$2.50/generics or \$6.30/brand names, or a 5% co-pay, *whichever is greater* (the co-pays in 2009 were \$2.40/\$6.00).

More information about the costs of Medicare coverage in 2010 can be found by contacting 1-800-MEDICARE (1-800-633-4227).

PACE and Medicare 2010

PACE and PACENET members will be receiving letters in upcoming weeks as the start of the Medicare Open Enrollment Period nears. Every year, the PACE/PACENET program partners with a number of Part D plans and will auto-enroll certain members who do not have Part D coverage into one of their “partner” plans. PACE/PACENET recently announced their 2010 partner plans:

- CCRx Basic
- Advantage Star Plan (Rx America)
- AARP Medicare Rx Saver
- Fox Insurance Company

CCRx, Advantage Star Plan and AARP Medicare Rx Saver are current partner plans. Fox Insurance Company is a new Part D plan starting in 2010. PACE/PACENET will no longer partner with AmeriHealth Advantage Rx Option 1 or First Health Part D Premier after December 31, 2009.

PACE/PACENET is currently sending out notices to its members to let individuals know if the Program recommends that they keep their current coverage, change their current coverage, or if the Program will take action to auto-enroll them into a partner plan for 2010. Consumers should make sure to read the notice carefully or show it to a family member or professional for assistance.

If the Program indicates that they will auto-enroll the member into a partner plan for coverage starting 1/1/2010, but the consumer does not want to be enrolled in any Part D Plan or prefers a different plan than the one PACE/PACENET chose, he needs to call the PACE/PACENET Program by **November 25, 2009** and make his wishes known. If the person does not respond to the letter, PACE/PACENET will proceed to auto-enroll the person into the specified partner Part D plan effective 1/1/2010.

Note: This is especially important for people who are currently enrolled in a Medicare Advantage plan. If PACE/PACENET does not know that someone is in a Medicare Advantage plan, the Program may take action to auto-enroll him in a partner plan. This could then cause the individual to lose their Medicare Advantage coverage. If a PACE/PACENET member wishes to remain in their Medicare Advantage plan, he will need to notify PACE about this.

Keep in mind that when PACE/PACENET auto-enrolls a member into a Partner plan, it uses an “intelligent assignment” process which means it reviews the medications consumers take, and the pharmacy(ies) they prefer and auto-enrolls members into the partner plan that will best meet their needs. Also keep in mind that PACE and PACENET are “creditable” coverage (prescription coverage as good as or better than Part D) which means that members do not need to be enrolled in a Part D plan.

For more information on PACE/PACENET auto-enrollment and how PACE/PACENET coverage work together, go to the Department of Aging website at www.aging.state.pa.us.

Final Form of Home Care Licensure Regulations Approved by IRRC

Final regulations governing the operation of home care agencies and registries in Pennsylvania were approved by the Independent Regulatory Review Commission (IRRC) on October 1, 2009. The regulations have been sent to the Office of the Attorney General for final approval. If the Attorney General approves the regulations, they will be published in the *Pennsylvania Bulletin* as final rulemaking effective November 14, 2009.

Act 69 of 2006 (P.L. 334, No. 69) amended the Health Care Facilities Act (38 P.S. ss.448.101 – 448.904) and set minimum standards for the operation and licensure of home care agencies (HCAs) and home care registries (HCRs). It also required the Department of Health (DOH) to promulgate regulations governing the licensure of HCAs and HCRs.

Home care agencies employ direct care workers. Home care registries include listings of direct care workers (independent contractors) who provide home care services to individuals in their home or other independent living environments. Home care services include assistance with activities of daily living (such as bathing, dressing, grooming, and eating) and instrumental activities of daily living (such as companionship, respite care, meal preparation) and other non-medical services.

The regulations formalize and standardize some industry practices that are already in place. They also provide the DOH with a mechanism for enforcing important protections for consumers. These regulations are particularly important because many Pennsylvanians with long-term care insurance could not obtain coverage for their home care because the HCA or HCR was not licensed.

Under the approved regulations, home care agencies and registries are required to:

- Conduct criminal background checks on all staff.
- Ensure the competency of individuals that provide care by making sure they have passed a competency examination for persons only providing activities of daily living, possess a valid nurse's license, or have successfully completed a state-approved nurse aide or personal care training program.
- Comply with some important consumer protection requirements including, but not limited to, providing information to consumers about:
 - their right to be involved in the service-planning process.
 - their right to receive ten (10) days' advance notice of termination of service(s).
 - the services that will be provided, the hours when services will be provided, fees and total costs.
 - their right to access the Department of Health's 24-hour hotline and the local Ombuds-person program.
 - whether the consumer's direct care worker is an employee of a home care agency or independent contractor.

Additionally, under the approved regulations an HCA or an HCR cannot assume power of attorney or guardianship over a consumer utilizing their services and cannot require a consumer to endorse checks over to them.

For more information on Act 69, contact the Department of Health's Division of Home Health at 1-877-PA-HEALTH (1-877-724-3258).

PHLP Says Farewell To Alissa Halperin

PHLP Attorney Alissa Halperin has left the organization at the end of October to open a health consulting practice. The timing was sudden but necessary. On November 1st, Alissa began consulting with the Commonwealth's Office of Long Term Living to improve health care for low-income people who are elderly or disabled and covered by both Medicare and Medicaid.

Alissa joined PHLP in 1999 as an Independence Foundation Public Interest Law Fellow. Through her tenure she worked on every facet of PHLP strategy (e.g., individual counseling and representation, impact litigation, community education, systemic policy advocacy) and literally improved thousands of lives. Alissa also served as the Managing Attorney of PHLP's Philadelphia office, introducing new systems that improved productivity and guiding many PHLP staff and student interns.

Recently, Alissa received local and national attention for her leadership of the Pennsylvania Assisted Living Consumer Alliance (PALCA), a network of 33 organizations representing seniors and persons with disabilities. Supported by the Pew Fund for Health and Human Services, PALCA advocates for the development of standards for assisted living facilities that exceed the standards currently in place for personal care homes. Personal care home regulations have been minimal and enforcement lax, resulting in numerous incidents of resident abuse or neglect, sometimes resulting in the death of the resident. Final assisted living regulations are expected to be released later this year and recent drafts contain PALCA language that improve residents' rights, staff qualifications, physical site design, fire and safety codes, and consumer choice.

It's hard to imagine PHLP without Alissa. She has been an important part of PHLP providing strong, effective advocacy and leadership. We wish her much success with her new practice.

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Free Day-Long Trainings to Focus on Behavioral Health Issues in Older Adults

The PA Behavioral Health & Aging Coalition and Behavioral Health Connection are holding training sessions for mental health professionals, aging professionals, senior center staff and consumers of mental health services. The trainings will provide information so attendees develop a basic understanding of Medicare and accessing Medicare services for mental health consumers. Presentations will focus on behavioral health issues common to the older adult population. The presenters will share actual case studies to help participants better understand the issues involved in serving “baby boomers”, those dealing with substance use, and other older adults. The goal of the training is to help professionals assist their consumers who are having difficulty accessing behavioral health treatment and take advantage of services provided by Behavioral Health Connection and APPRISE.

A training session was held on November 4, 2009. The other scheduled training session will be:
December 2, 2009 – York County Annex Building
118 Pleasant Acres Road, York, PA 17402
Meeting Room 1

Sessions are held from 9:00am – 3:00pm. Continental breakfast and lunch will be provided.

For further information or to register, contact Lynn Patrone at 717-541-4219 or lynn@olderpennsylvanians.org.



Pennsylvania Health Law Project
The Corn Exchange
123 Chestnut St., Suite 400
Philadelphia, PA 19106