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Assisted Living Regulations Released!

On May 3, 2010, the Department of Public Welfare issued final-form regulations for the licensure of assisted living facilities. These are residences that provide food, shelter, personal care assistance and some health coverage to elderly and disabled residents who are not so sick as to require ongoing skilled nursing care. About 50,000 people in Pennsylvania currently live in facilities that may call themselves assisted living facilities but that are actually licensed by the Commonwealth of Pennsylvania as personal care homes.

The final-form regulations detail licensure standards for assisted living facilities. The Pennsylvania Assisted Living Consumer Alliance (PALCA), a collaboration of consumers, family members, and local and state wide organizations, have sought regulations that hold assisted living facilities to higher standards than the current personal care home standards; regulations that require a standardized minimum benefit package for consumers who want independence, privacy, and choice, but who also want the ability to "age in place" (meaning they won't have to move when their care needs increase). In contrast, the long-term care provider industry, led by its for-profit and non-profit associations, has sought minimal regulatory requirements.

Pursuant to the Regulatory Review Act, the final-form regulations will now be reviewed by the Independent Regulatory Review Commission (IRRC) and the Standing Committees in the PA House (Aging and Older Adult Services) and the PA Senate (Public Health and Welfare). The IRRC will hold a public meeting on these regulations on June 3, 2010 at 10 AM. Details about this meeting, including the agenda and meeting location will be posted on IRRC's website: www.irrc.state.pa.us. A copy of the final-form regulations are available at the following link: www.irrc.state.pa.us/Documents/SRCDocuments/Regulations/2712/AGENCY/Document-17996.pdf

Written comments on the regulations may be submitted to the IRRC, the Standing Committees, and/or individual legislators (www.legis.state.pa.us). The IRRC will take written testimony and comments until June 1st. The Standing Committees, which will also review and take action on the regulations, will receive written comments up to 24 hours before the IRRC public meeting (which would be 10 AM on June 2, 2010, for this regulation). Individuals interested in submitting written comments should do so early rather than waiting until the end of the comment period. Written comments may be sent to the IRRC by fax at 717-783-2664, by e-mail to irrc@irrc.state.pa.us, or by regular mail to: Independent Regulatory Review Commission, 333 Market Street, 14th Floor, Harrisburg PA, 17101. Written comments should reference the ID number for this regulation: #12-514 (#2712).

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PALCA is in the process of reviewing and analyzing the final-form regulations. Its analysis will soon be posted to the PALCA web site (www.paassistedlivingconsumeralliance.org).

If the regulations are approved, DPW will submit them to the Attorney General for review for form and legality. After the Attorney General's review is complete, the regulations will be published in the *Pennsylvania Bulletin* as final rulemaking (anticipated by the end of July 2010) and will become effective six months after the date of publication.

CMS To Terminate a Special Needs Plan in Western PA

The Centers for Medicare & Medicaid Services (CMS) is taking steps to terminate a new dual eligible Special Needs Plan (SNP) in Western Pennsylvania, UPMC for Community Living, because it does not have a signed contract with the Department of Public Welfare as required by Medicare rules and regulations. UPMC for Community Living is a new dual SNP that started January 1, 2010. It is available in 23 counties in Western PA and its membership is limited to individuals with Medicare and Medicaid who are 60 years of age and older. There are approximately 1,700 members in this plan. CMS is finalizing the language on the notices that will be sent to affected members in upcoming weeks and they are notifying partners such as the APPRISE program about the termination. The termination date will likely be July l, 2010.

CMS' decision to terminate this plan came about as a direct result of advocacy by PHLP staff and national advocates. PHLP learned about this plan in late 2009 from clients who received marketing material from UMPC encouraging them to disenroll from UPMC for Life Specialty Plan and instead enroll into this new Plan which offered extra benefits.

PHLP questioned whether the plan could legally limit its enrollment to dual eligibles 60 and older (as opposed to all duals) and whether it could offer enhanced supplemental benefits (specifically, dental, vision and hearing coverage) to seniors that were not available to the younger disabled dual eligibles whose only choice for a Medicare Special Needs Plan through UPMC Health Plan was the UPMC for Life Specialty Plan. Together with national advocates (specifically, the National Senior Citizen Law Center and the Center for Medicare Advocacy), PHLP contacted CMS and raised these concerns. After several months of discussion on this issue and after CMS investigated the matter, CMS concluded that UPMC for Community Living was not in compliance with Medicare rules because it failed to have a signed contract with the state Medicaid agency, the Department of Public Welfare, and CMS agreed that the plan should not continue.

Members of the UPMC for Community Living SNP will be enrolled into the UPMC for Life Specialty Plan for coverage once the Community Living plan ends. However, members also have the option of joining another Medicare Special Needs Plan for dual eligibles available in their area, or they can go back to Original Medicare and join a stand-alone Prescription Drug Plan. Affected members will receive written notice about this and their options for coverage in upcoming weeks. Individuals who have questions about their options for Medicare coverage can contact PHLP's HELPLINE at 1-800-274-3258.

2010 Federal Poverty Guidelines Update

The 2009 Federal Poverty Guidelines continue to remain in effect for income-based programs (such as Medical Assistance and the Medicare Part D Low-Income Subsidy Program) until at least May 31, 2010.

We will post information about the updated 2010 Federal Poverty Guidelines on our website, www.phlp.org, when the information becomes available.

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Medicare Suspends Enrollment in Aetna Medicare Plans

The Centers for Medicare & Medicaid Services (CMS) ordered Aetna to stop marketing to and enrolling new members into any of its Medicare Advantage plans (with drug coverage) and its stand-alone Prescription Drug Plans effective April 21st. The suspension is the result of Aetna's failure to follow Medicare rules regarding transition processes and handling formulary exception requests. Aetna changed from an open formulary to a closed formulary in 2010 for many of its plans and as a result, thousands of members were unable to get needed medications because they were no longer covered. Under Medicare rules, Part D plans have to provide a one-time fill of medications that an individual had been taking prior to the formulary change to give members time to request a formulary exception. Aetna failed to provide the temporary fills.

Aetna also did not follow Medicare rules for handling formulary exception requests and failed to meet the timeframes for deciding expedited cases (where an individual's health condition requires a quicker decision). Aetna also had utilization management requirements for medications that had not been approved by CMS.

The suspension will be in effect until Aetna can demonstrate to CMS that it has corrected the problems and that the problems are not likely to recur. Currently, Aetna has approximately 400,000 members nationwide in Medicare Advantage plans with prescription drug coverage and approximately 600,000 members in its stand-alone prescription drug programs. If current Aetna members are having problems getting their medications, they should call 1-800-MEDICARE or the APPRISE program at 1-800-783-7067.

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.

OLTL Continues Work on Integrated Care Initiative

Although implementation of the Integrated Care Initiative (ICI) has been tabled indefinitely, PHLP has learned that the Office of Long Term Living (OLTL) continues to work on this program to give a developed model to the next gubernatorial administration. OLTL continues to research various laws that impact the development of ICI, learn more about how the ICI models work, and meet with Area Agencies on Aging and the Medicare Special Needs Plans in Southwestern PA (where ICI was scheduled to pilot before the decision was made to not move forward in this administration).

In late April, OLTL resumed its statewide stakeholder conference calls to provide information, gather input, and hear concerns. During an April 29th meeting, consumers voiced concern and frustration over the state's exclusive focus on using Medicare Special Needs Plans to integrate care and on the fact that consumers have been left out of the continued work by OLTL to develop the ICI model. OLTL said they plan to meet with consumers and their advocates in Southwestern PA as well as continue to hold statewide stakeholder calls in upcoming months. Individuals who are interested in the future meetings, please see http://www.dpw.state.pa.us/about/oltl/snp/default.htm or contact OLTL at (717) 772-2526 or RA-IntegratedCareComments@state.pa.us to be notified of upcoming meetings as they are scheduled.

PHLP is interested in hearing from dual eligible consumers living in southwestern Pennsylvania who are 60 and older, their caregivers and advocates, and healthcare and social service providers who serve elderly persons in southwestern Pennsylvania and who are interested in attending any consumer meetings in Southwestern PA about the ICI. If you are interested, please contact PHLP's Helpline at 1-800-274-3258 or email fchervenak@phlp.org.

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Health Care Reform's Impact on Older Adults and Persons with Disabilities

Health Care Reform legislation was passed in March and contains a number of provisions impacting older adults and persons with disabilities. Here are some highlights of the Patient Protection and Affordable Care Act of 2010 (the Act):

Part D Doughnut Hole:

One of the biggest changes to the Medicare program is the eventual elimination of the "doughnut hole." The Medicare Part D program was established in 2006 to help cover prescription drugs for Medicare beneficiaries. However, the Part D benefit includes a coverage gap where individuals must pay thousands of dollars for their meds. Currently, all prescription drug costs between $2,830 and $6,440 have to be paid "out of pocket" by the consumer (unless the individual gets "Extra Help" from Medicare or is eligible for help through a program like PACE/PACENET).

Although the Act will not eliminate the doughnut hole coverage gap until 2020, some assistance will be provided sooner. Later in this calendar year, Medicare consumers who reach the donut hole will automatically receive a $250 rebate; and, between 2011-2019, Medicare beneficiaries will receive additional discounts and subsidies to reduce cost-sharing for those who reach the doughnut hole. This change will benefit hundreds of thousands of Pennsylvanians.

Changes to Medicare Enrollment Periods:

Starting in the fall of 2011, the Medicare Annual Open Enrollment Period will be October 15th through December 7th of each year instead of November 15th through December 31st. During the Annual Open Enrollment Period, individuals can enroll or disenroll from Part D and change their Medicare Advantage Plan or their Medicare Prescription Drug Plan. The change to the Annual Open Enrollment Period was made to allow time for the systems to update by January 1st and because of advocacy done by benefits counselors who requested that the enrollment period happen earlier in the fall.

The Medicare Advantage Open Enrollment Period (January 1-March 31st of each year) has been eliminated. The Medicare Advantage Open Enrollment period allowed individuals to change their Medicare Advantage plan, enroll in a Medicare Advantage Plan, or disenroll from a Medicare Advantage plan and go back to Original Medicare and get a stand-alone Prescription drug plan. Individuals could not add or drop drug coverage during this enrollment period. Although this enrollment period is now gone, individuals in a Medicare Advantage plan will have a 45 day period at the beginning of each year to disenroll from their Medicare Advantage Plan and go back to Original Medicare and join a stand-alone Part D plan. This annual 45 day period starts January 1, 2011 and runs until February 15th.

Medicare Preventive Services Coverage:

Starting January 2011, Medicare will cover an annual wellness visit every 12 months (starting 12 months after the Welcome to Medicare exam). There will be no cost-sharing (Medicare Part B deductible or coinsurance) for this annual wellness visit or for other Medicare-covered preventive and screening services starting January 2011.

Elimination of co-pays for full dual eligibles receiving HCBS Waiver Services:

Currently, individuals who have Medicare and full Medicaid benefits and live in a nursing home do not pay any Part D co-pays. However, anyone on Medicare and full Medicaid who receives long-term care services in the community (*i.e.*, through a Home and Community Based Services (HCBS) Waiver like the Aging Waiver or Independence Waiver) is required to pay Part D co-pays ranging from $1.10 to $6.30 per medication.

Starting in 2011, Medicare beneficiaries who also receive full Medicaid and who are in a

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HCBS Waiver program will not have any Part D co-pays for drugs that are covered by their Part D plan and received at an in-network pharmacy.

Options for states to Increase use of HCBS Waiver Services:

The Act includes a number of provisions that allow states more flexibility in the design of their home and community based waiver programs and provides financial incentives to encourage states to reduce the amount of Medicaid dollars spent on costly institutional care by increasing options for individuals to receive long-term care supports in their home and community. Pennsylvania currently spends only 22% of their long term care budget on home and community based long-term care services, with the rest going to institutional care. Health care reform provides opportunities for the Commonwealth to increase the percentage of dollars used to support home and community based care and to apply for enhanced funding from the federal government to support the expansion of these programs.

Expansion of Medicaid:

Beginning in 2014, states will be required to extend Medicaid coverage to all individuals under 65 years old, regardless of their resources, whose income is less than 133% of the federal poverty level (currently $1,200/month for a single person and $2,444/month for a family of 4). In addition, states are barred from changing their eligibility requirements in a way that restricts enrollment for Medicaid before 2014. This Medicaid expansion will help provide coverage to uninsured or underinsured low-income older adults and persons with disabilities before they can get Medicare.

Health reform includes many more important changes to health care coverage and delivery than those highlighted above. The details of implementing the various parts of the Act will be developed over upcoming months and years. Stay tuned to future newsletters and our website (www.phlp.org) for updates on the implementation of health care reform.

Advocates Can Help PCH Residents Understand and Enforce Their Rights

Personal care homes are residential facilities that offer personal care services, assistance and supervision to its residents. They are inspected and licensed by the Pennsylvania Department of Public Welfare. A personal care home with 4 or more persons must have a license in order to operate in Pennsylvania. There are state regulations that apply to licensed personal care homes. These regulations are aimed at protecting the health, safety and well-being of the residents. There are no federal regulations for personal care homes. Nearly 50,000 Pennsylvanians live in Personal Care Homes (PCHs). Sometimes they are advertised as "assisted living residences" or "retirement homes". As of December 31, 2009, there were 1,424 licensed personal care homes in Pennsylvania. Statewide, 82% of PCH residents are age 60 or older.

The regulations licensed personal care homes must comply with were updated in 2005 to improve the health, safety, well-being and quality of life for individuals living in these residences. Despite the regulatory improvements, ensuring compliance remains a challenge. The Department of Public Welfare's Office of Adult Residential Licensing's 2009 Annual Report on Personal Care Homes confirms a total of 18,873 regulatory violations identified during inspections. The most common violations present serious and life-threatening health safety risks to this vulnerable population of PA residents including:

- improper documentation of medication administration,
- inability to evacuate residents quickly in the event of a fire or emergency,
- failure to keep poisons locked and inaccessible to residents, and
- failure to perform criminal history background checks on staff persons.

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These violations represent the failure of many PCH administrators to provide one of the most basic human needs – ensuring the health and safety of the individuals entrusted to their care. Violations of other regulations impacting the quality of life for PCH residents are more challenging to identify. While health and safety violations jeopardize the residents' survival, violations of individuals' rights jeopardize their basic freedoms and quality of life.

A resident who lives in a personal care home has many rights. For example, residents may not be discriminated against for any reason and must be treated with dignity and respect. Residents have the right to private communication by telephone and mail as well as with visitors. Residents have the right to receive assistance accessing health services and the right to get those services from a provider of their choosing. Those residing in PCHs are entitled to furnish their rooms and obtain and retain personal clothing and possessions. Residents also have the right: to receive visitors for a minimum of 12 hours daily, 7 days per week; to privacy of self and possessions; and to leave and return to the PCH consistent with home rules and the individual's support plan. Residents also have the right to file complaints with any individual or agency and to recommend changes in policies, rules and services of the home without intimidation, retaliation or threat of discharge.

Though these rights and others are clearly laid out in the PCH regulations, advocates and other stakeholders repeatedly receive reports about PCH violations of these rights. Residents report being told to give away or throw away their clothing because they have "too much stuff." Others share not being "allowed" to attend day programming in the community because they "misbehaved." Residents are told when and where to walk or exercise. Others report not being "allowed" to have a cell phone despite having personal funds to pay for one. These generally subtle violations of individuals' rights are often very difficult for DPW licensing staff to identify. Personal care home residents often share these issues only with those they trust for fear of the very retaliation and intimidation the regulations should protect them from.

Advocates and families can help those living in PCHs know their rights and be a voice for those who feel too intimidated to speak for themselves. Personal Care Home regulations which include all of the residents' rights are located in the Pennsylvania Code at http://www.pacode.com/secure/data/055/chapter2600/chap2600toc.html. PCHs are required to inform residents about their rights upon admission to the home and they are required to post a list of resident's rights in an area of the home where residents and visitors can easily see it. For PCH residents aged 60 and older whose rights are being violated, advocates can contact their county Area Agency on Aging's Ombudsman. Violations effecting residents under 60 can be reported to the Disability Rights Network intake line at 1-800-692-7443 or intake@drnpa.org. In addition, violations affecting all PCH residents can be reported to one of the Department of Public Welfare's Office of Adult Residential Licensing Field Offices. The contact information for each county's ARL Field Office can be found at http://www.dpw.state.pa.us/ServicesPrograms/PhysicalDisabilities/003676426.htm.

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DPW Finalizes Process to Help Individuals Get MSP

In late February, the Department of Public Welfare (DPW) released its final policy for determining who qualifies for the Medicare Savings Program based on the data they receive from the Social Security Administration (SSA) and it is good news for consumers. Effective January 2010, the Medicare Improvements for Patients and Providers Act (MIPPA) requires that SSA send individual data to the states after it has decided whether an individual applicant qualifies for the Medicare Part D low-income subsidy (LIS), also called "extra help with Medicare prescription drug plan costs". MIPPA requires that states use the data from SSA to determine whether the individual also qualifies for help with Medicare cost-sharing available through the Medicare Savings Program (MSP). DPW, with input from PHLP and other consumer advocates, spent much of the last year developing their policy and procedures for dealing with this data. The final policy released in recent months reflects a coordinated effort to implement a consumer-friendly process that helps older adults and persons with disabilities who have limited income and resources with their Medicare costs.

The ***Medicare Savings Program*** helps Medicare beneficiaries with limited income and resources pay for their Medicare Part B premiums ($110.50 in 2010) and, in some cases, pay their Medicare Part A and B deductibles and coinsurance. The current guidelines to qualify for the Medicare Savings Program are:

- single person—income below $1,219/mo and resources below $6,600;
- married couples—income below $1,640/mo and resources below $9,910.

DPW's Policy for Processing MSP Applications based on LIS data from SSA

MIPPA requirements make it easier for low-income people to apply for and get the benefits of programs to help with their Medicare costs. Here is an outline of how DPW will use the data from SSA to determine whether someone qualifies for MSP:

- After SSA has determined whether or not an applicant is eligible for a Part D low-income subsidy, it will send all LIS data on that individual to DPW (unless the person noted on their LIS application that they did not wish SSA to share their data). DPW will treat this data received from SSA as an MSP application.
- DPW will determine whether the individual qualifies for MSP using only the LIS data they receive from SSA. This data does NOT include any information about life insurance or in-kind support and maintenance income--since this information is no longer collected or considered when determining LIS eligibility. DPW will accept the SSA/LIS application information at face value and will not look behind it by seeking any additional information or documentation/ verification from consumers.
- Consumers will receive notices telling them if they are eligible for MSP or not and providing information about appeal rights.
- If the person is approved for MSP, the DPW County Assistance Office will redetermine an individual's eligibility every 12 months. Please note that the individual **WILL** be asked to provide information about life insurance and in-kind support and maintenance at redetermination.

In addition to the information about redetermination listed above, it's important to note the following:

- Individuals who instead apply for MSP by completing an application (the PA-600M) and submitting it directly to the County Assistance Office in their area will have to provide information about their life insurance and in-kind support and maintenance income as well as documentation/verification of other application information (such as income and resources).

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- Depending on the individual's situation, it may be to her benefit to apply for LIS through SSA and have their MSP application generated that way.
- Individuals who already receive LIS will have to submit an application directly to their local County Assistance Office to qualify for MSP.
- The process described above differs from how the state initially thought it would handle the LIS data from SSA. Our October 2009 Senior Health Law Newsletter included information about a previous version of the process whereby the state proposed to send a data collection sheet to individuals whose data had been sent from SSA asking for additional information (i.e., about life insurance) and asking for verification documents before determining MSP eligibility. Consumer advocates are pleased that the state decided against using the data collection sheet and believe that easing the burden on consumers will result in more qualified individuals being able to take advantage of the program.
- Individuals who are interested in reading the entire policy can find it at this link: http://www.dpw.state.pa.us/oimpolicymanuals/manuals/bop/ops/OPS100203-2.pdf

Readers who have questions or who are having problems with eligibility for either MSP or LIS can contact PHLP's HELPLINE at 1-800-274-3258. Individuals who need help applying for either LIS or MSP can contact the APPRISE program at 1-800-783-7067.

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