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OLTL Bulletin Issued Detailing HCBS Waiver Changes

Pennsylvania's Office of Long Term Living (OLTL) recently released a bulletin to clarify a number of policy changes that apply to the Home and Community Based Services Waivers they administer in order to ensure the programs meet federal standards. OLTL currently administers the following HCBS Waiver programs: *Aging, AIDS, Attendant Care, OBRA, Independence, and Commcare.*

The bulletin went into effect July 1st. Although the bulletin was sent out as final, PHLP has learned OLTL is revising it due to the number of questions and requests for clarification the state received after it was issued. Important changes and clarifications discussed in the bulletin are:

An MA-51 form is no longer required to qualify for Waiver programs. Each Waiver program requires that an individual meet a certain level of care in order to qualify for services. In the past, the individual's doctor had to complete an MA-51 form to certify that he needs the appropriate level of care before he could be approved for the Waiver. OLTL developed a simpler physician certification form to replace the MA-51, but the form has not yet been finalized. Furthermore, the Bulletin clarifies that a physician's form or statement regarding level of care will not be required at annual reviews for people already on any of OLTL's Waivers.

Individuals can qualify for a Waiver program even if they can drive a car and/or leave their house, provided they meet the Waiver's functional and financial eligibility criteria. Waiver programs are available to provide individuals in need of long-term care services an alternative to nursing home care, allowing them to remain part of their community. This is often the preference of many individuals in need of long-term care services. This bulletin recognizes that any requirement that someone be totally homebound to qualify for Waiver services goes against the intent of the HCBS Waiver programs and is not a requirement of HCBS eligibility under the federal law.

Individuals who qualify for services under the Aging Waiver but who decline enrollment into the Waiver are <u>not</u> eligible to receive services under the Options Program. The Options Program provides adults over the age of 60 with certain supportive services if they do not otherwise qualify for the Aging Waiver (usually because someone's income and/or resources exceed the waiver limits). In the past, individuals who were eligible for the Aging Waiver but who declined to enroll in that program could choose to pay for services through the Options program. According to this Bulletin, these individuals will no longer have that choice.

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Waiver recipients must be given a list of all qualified Waiver providers in their area at the time of their enrollment into the Waiver program and at certain times following enroll ment. The Bulletin clarifies that ***individuals have a choice of which providers to use and do not have to get all their services through one provider.***

Waiver recipients can get their services from any willing and qualified provider who is enrolled in the Medical Assistance program. Local Waiver entities cannot place additional requirements on providers beyond those listed in the Waiver document that has been approved by the federal government.

The current bulletin can be viewed at http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003673169.aspx?BulletinId=4579. We'll update readers about further developments in upcoming newsletters.

State Developing Waiver to Help Low-Income Pennsylvanians Pay for Care in Assisted Living Residences

As we reported in our May Newsletter, regulations governing the licensure of Assisted Living Residences (ALRs) in Pennsylvania will go into effect on January 17, 2011. The new regulations will officially acknowledge and license assisted living residences as a long term care option between the personal care home and nursing home levels of care.

Now that "Assisted Living Residence" is an official licensure designation, Pennsylvania announced it intends to submit an application to the Centers for Medicare and Medicaid Services (CMS) seeking a Medicaid Waiver that will allow the state Medicaid program to pay for services in an assisted living residence for qualified individuals with limited income. Under the Waiver, if approved, Medicaid funding would support approximately 279 assisted living residents.

The Department of Public Welfare (DPW) has engaged an outside consultant to help them develop the assisted living Waiver application that will be submitted to CMS for approval. Additionally, DPW is seeking input from an Assisted Living Waiver Stakeholder Workgroup consisting of consumers, advocates, assisted living providers and provider organizations. PHLP participates in this Workgroup as counsel to the Consumer Subcommittee of DPW's Medical Assistance Advisory Committee. Consumers and advocates within the Workgroup have raised several issues to improve access and quality:

Room holds for residents during hospitalization. Unless Pennsylvania pays to hold the resident's room while he is hospitalized, the facility could move another person into the room and then refuse to readmit the resident once discharged from the hospital. This could leave the resident with no other option than a nursing home for ongoing care.

Access to Medicaid payment after a facility withdraws from the Waiver program. Pennsylvania should require ALRs who voluntarily withdraw from the Medicaid program to continue accepting Medicaid waiver reimbursement on behalf of individuals already admitted and receiving

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Waiver funding. This would prevent the resident from being forced to leave when the Waiver stops paying for services and she cannot afford to pay for care on her own.

Provider choice for supplemental health care providers. Pennsylvania should allow assisted living Waiver recipients to retain their choice of doctors while in a Medicaid-certified ALR.

Medicaid rate as payment in full. Pennsylvania should require Medicaid-certified ALRs accept the Medicaid rate as "payment in full", meaning that the ALR would not be able to seek supplemental payment from the resident's friends or family members for services paid for by the Waiver.

The state initially anticipated submitting the Waiver application to CMS by August 31, 2010, but it has been delayed. DPW now expects to submit the Waiver application to CMS by the end of October and, if approved, have the Waiver operating by next spring. PHLP's Web site (www.phlp.org) and future newsletters will have more information about the development of the Assisted Living Waiver.

Medicare Announces 2011 Low-Income Benchmark Amounts

Medicare recently announced the 2011 low-income benchmark premium amounts. Pennsylvania's 2011 benchmark premium will be $34.07. Therefore, individuals with the full low income subsidy from Medicare who are enrolled in a standard Part D plan with a monthly premium less than $34.07 will not have to pay a Part D premium. Medicare will announce the 2011 Medicare Part D plans later in September. PHLP's website (www.phlp.org) will list which of those will be Standard Zero-Premium Prescription Drug Plans for individuals with the full subsidy.

The Affordable Care Act (ACA), as the federal Health Reform legislation is known, requires improving the benchmark amounts determinations. In addition, the ACA reinstated a policy that allows Part D plans whose premium is less than $2 over the benchmark to waive the entire premium for individuals receiving the full subsidy. The plans that will take advantage of this policy in 2011 will also be announced by late September. These two changes are important because fewer low-income consumers receiving the full subsidy will have to be reassigned to a different plan for 2011 because of increased plan premiums. Medicare estimates that only 500,000 low-income consumers across the country will have to be reassigned to new Part D plans for 2011 compared to the 1.2 million people who would have had to be reassigned had these two changes not taken place. Our next edition of the SHN will include more information about Part D reassignments.

Medicare expects to announce the 2011 Medicare Part D and Medicare Advantage Plans in September. General plan information should be available on www.medicare.gov on October 2nd with more detailed plan information available on October 8th.

Reviews of Medicare Part D Low-Income Subsidy Eligibility for 2011 Now Underway!

Each fall, Medicare and the Social Security Administration take steps to see if individuals currently receiving the Part D low-income subsidy (also called Extra Help) will continue to qualify for this benefit in the next calendar year. Here's an update about the review processes:

Reviewing Medicare beneficiaries who also get some help from Medical Assistance/ Medicaid:

Every month, the Pennsylvania Department of Public Welfare (DPW) sends Medicare a file of individuals who received help from Medicaid during that month. Medicare then automatically gives these individuals a full low-income subsidy (LIS) for the remainder of the year. Any person who appears in the file sent in July is given the full LIS for the rest of 2010 and for all of 2011. Remember, **anyone** who gets **any** help from Medicaid automatically qualifies for the full low-income subsidy even if their income/resources are above the LIS guidelines (this often includes people getting Medicaid benefits through the MAWD program, through a Home and Community Based Waiver Program, or someone getting Medicaid to cover nursing home care).

- Individuals who had Medicaid at any point during 2010 and who will continue to qualify for full LIS in 2011 with no change to their co-pay amounts will not get any notice. So, no news is good news in this case.

- Individuals who continue to qualify for an LIS but who will have different co-pays in 2011 will get a notice on orange paper. An individual's co-payments could change because they went into a nursing home, had a change to their Medicaid category, or had a change in their income.

- Individuals who will no longer automatically qualify for LIS in 2011 will get a notice on grey paper along with an Extra Help application. Those who lost their Medicaid benefits prior to July 2010, for example, should get this notice. These individuals may still qualify for the Extra Help in 2011 but they will have to send an application to the Social Security Administration and be found eligible.

The notices on orange and grey paper will be mailed by early October. Copies of sample notices can be viewed at: http://www.cms.gov/LimitedIncomeandResources/LISNoticesMailings/list.asp#TopOfPage.

Remember, individuals who are found eligible for Medicaid between August and December, 2010 will get the full low income subsidy automatically for the remainder of the 2010 and for all of 2011.

Reviewing Individuals found eligible for the LIS by Social Security:

Medicare beneficiaries who do not get any help from Medicaid must apply to the Social Security Administration (SSA) and be found eligible to get the low-income subsidy. Each year, SSA chooses certain individuals to review their eligibility for LIS and see if they continue to qualify for this help or not.

This year, SSA will be reviewing 400,000 LIS recipients across the country. Those chosen for review should get a form in the mail in September that they have to complete and return within 30 days (even if nothing in their financial circumstances has changed). After SSA completes the review, they will send notices to all individuals telling the person whether her low-income subsidy is unchanged for 2011, whether her LIS level will increase or decrease in 2011, or whether her LIS will be terminated at the end of the year.

Please contact PHLP's HELPLINE at 1-800-274-3258 with questions about LIS eligibility or about any notices received.

It's Almost Flu Season Again: What You Need to Know About Medicare's Vaccine Coverage

Fall is around the corner, and doctors and television advertisements are telling everyone to get a flu shot. This is a good time to review what immunizations are recommended for seniors, and whether Medicare covers them.

Flu Shots: Flu shots are recommended for everyone over 6 months of age, but especially for people 65 or older. Influenza, the official name for the flu, is not just a bad cold or a stomach virus, but a serious illness with high fevers, cough, and muscle aches. People over 65 are much more likely to die from influenza than younger people. Because the kind of flu changes every year, people must get a shot every year. Medicare Part B pays for flu shots. If someone has traditional Medicare, he can get a flu shot at his doctor's office, or at a clinic or pharmacy that will bill Medicare. If someone gets their Medicare benefits through a Medicare Advantage Plan (i.e. a Medicare HMO), he will need to get the shot at his doctor's office.

Pneumonia Shots: Pneumococcal vaccine (brand name Pneumovaxa®) is a one time shot to protect people from getting the most common kind of pneumonia but it does not prevent every kind of pneumonia. It is recommended for everyone at age 65. If someone received the vaccination before age 65 because she is a smoker, or she has asthma or other lung disease, a second shot at age 65 is recommended. Medicare Part B covers the pneumonia shot under the same rules as the flu shot noted above.

Tetanus Shots: Most adults in the United States received tetanus shots as children, and boosters either routinely or after an injury. Tetanus shots are recommended every 10 years throughout life as prevention. However, Medicare does *not* cover them for prevention. Medicare will pay for a tetanus shot if someone has an injury, and if the doctor bills for examining and treating the injury at the same visit as the tetanus shot.

Zoster (shingles) Vaccine: Shingles is a common illness, especially in people over 65. Its official name is Herpes Zoster. It is a very painful rash that can leave a person with chronic severe nerve pain even after the rash is gone. A vaccine to prevent Zoster has been available for several years and is recommended for everyone over age 60. However, the vaccine is difficult to obtain because it is paid for under Medicare Part D (the Medicare prescription drug plan). As a result, only pharmacies, not doctors, can bill a Part D plan for it. In Pennsylvania, many pharmacies now stock Zoster vaccine and the pharmacist is licensed to give you the shot. However, a doctor must first write a prescription.

After someone gets a prescription, he can take it to the pharmacy and ask the pharmacist to confirm that it will be covered by his Part D plan and find out how much it will cost. Individuals who qualify for a low-income subsidy (LIS), will pay their LIS co-pay for a brand-name drug. Individuals without the LIS will be responsible for a portion of the cost depending on their plan and what stage of coverage they are in (i.e., "the doughnut hole").

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Upcoming PHLP Trainings on Medicare 2011

January 2011 brings Part D changes as well as changes to the Medicare program as a result of Health Care Reform. Come to a training to learn about these topics and others: ***Part D costs and options in 2011, Changes to Medicare's coverage of preventive services, and Changes to Medicare enrollment periods.***

October 28, 2010-9:30-11:30am Butler County Library Meeting Room-Lower Level 218 N. McKean St. Butler, PA 16001	**November 2, 2010-1:30-3:30pm** Allegheny General Hospital, Magovern Conference Center-Snyder Auditorium 320 East North Ave. Pittsburgh, PA 15212
November 9, 2010-9:30-11:30am Philadelphia Bar Association 1101 Market Street, 11th Floor Philadelphia, PA 19107	*Other Dates and Locations* *To Be Determined*

Contact PHLP's HELPLINE at 1-800-274-3258 or e-mail staff@phlp.org to RSVP.

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