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Assisted Living Regulations Now In Effect

Regulations governing the licensure of assisted living facilities in Pennsylvania went into effect January 18, 2011. A licensed assisted living facility (ALF) must provide food, shelter, certain health care services and assistance or supervision with activities of daily living (e.g., dressing, bathing, diet) to a group of four or more unrelated adults. ALFs combine housing and supportive services to allow people to age in place, maintain their independence, and exercise decision-making and personal choice.

With the new regulations, licensed ALFs offer their residents more stability. Before the ALF regulations went into effect, residences calling themselves Assisted Living Facilities were licensed as Personal Care Homes. The main distinction between Personal Care Homes and newly-licensed ALFs is the level of care. Personal Care Homes cannot provide medical services such as occupational and physical therapy, hospice services, and skilled nursing services. As a result, Personal Care Home residents whose care needs increase to require these services have to either move to a nursing home or receive long-term care services through a Home and Community Based Services Waiver Program. Licensed ALFs, on the other hand, may provide such medical services to residents who need them.

Now that the regulations are in effect, any facility that has “assisted living” in its name must either be licensed as an ALF or change its name. This requirement extends to how the facility presents itself to the community (such as on the Internet or in marketing materials) as well as using the term “assisted living” on internal forms, signs or contracts.

The Office of Long Term Living (OLTL) has received a number of ALF applications and is reviewing them. Once the state’s review is complete, OLTL will inspect facilities for licensure. To date, no residence has received an assisted living license. Therefore, consumers and their family members are advised that facilities currently using the term “assisted living” are not yet licensed as an ALF. The best way to find out whether a facility is licensed as a Personal Care Home or an Assisted Living Facility is to ask the provider. If the facility is not a licensed ALF, consumers should ask whether the facility intends to apply for licensure. When a facility not seeking ALF licensure is found to be using the “assisted living” term when marketing itself, the state will issue a correction and timeframes for compliance. PHLP is concerned about these marketing practices and invites calls to our Helpline (800-274-3258). For more information about Assisted Living Licensure, see http://www.aging.state.pa.us/portal/server.pt/community/assisted_living/19891.

New Administration In Harrisburg; Faces Huge Budget Deficit

Readers are already aware that our state is under new leadership. Tom Corbett was sworn in as Pennsylvania's new Governor on January 18, 2011. Since then, Governor Corbett has nominated several new people to his cabinet who will impact health policies and practices. These individuals are referred to as "Acting" until their nominations are confirmed by the state Senate:

- **Gary Alexander** has been chosen to be Secretary of the Department of Public Welfare (DPW). He comes to Pennsylvania from Rhode Island where he was the Director of the Department of Human Services. In that role, he spearheaded obtaining federal approval for the nation's first "Global Medicaid Waiver" in which Rhode Island agreed to limited federal aid for its Medicaid program in exchange for loosened federal oversight and more state flexibility in administering the program. That waiver has been controversial and advocates have voiced concern over the pursuit of a similar waiver here.
- **Brian Duke** has been chosen to be Secretary of the Department of Aging. Mr. Duke had been the Director of the Bucks County Area Agency on Aging.
- **Michael F. Consedine**, a private attorney, has been chosen to be the State's Insurance Commissioner.
- **Dr. Eli N. Avila**, a practicing physician and attorney has been chosen for Secretary of Health. Dr. Avila previously served as Chief Deputy Commissioner of Health for Suffolk County, New York.

2011-2012 Budget

Because the Governor is forming a new administration, he was given until March to propose a state budget for FY 2011-2012 (normally the budget would be proposed in February). The Governor's budget address is scheduled for March 8th. The state's projected budget deficit for the next fiscal year is estimated to be $4 billion. Medicaid accounts for approximately 20% of the state budget. To address the deficit and reduce spending, it is almost certain that the Governor will propose cuts and other changes to the state's Medicaid program. Once the proposed budget is presented, PHLP will analyze the impact on Medicaid consumers and those who benefit from other health care programs funded by the state and share that with our readers as quickly as possible.

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Changing Medicare Part D plans: Review of Common Special Enrollment Periods

The Medicare Annual Disenrollment Period (Jan. 1 – Feb. 14) has ended; therefore Medicare beneficiaries can only change their Part D plan now if they qualify for a Special Enrollment Period (SEP). There are a number of reasons someone could qualify for a Part D SEP—e.g., moving out of their plan's service area, entering or leaving an institution such as a nursing home, becoming a dual eligible, or qualifying for the low-income subsidy ("extra help"). Depending on an individual's circumstance, the Special Enrollment Period she qualifies for may limit the types of choices that can be made and the amount of time she has to make a change. Below we review some of the more common Part D SEPs for our readers:

- ***SEP for Dual-Eligible Individuals***: Any Medicare beneficiary who qualifies for Medicaid (either full coverage or just partial help such as payment of the Part B premium) is a dual-eligible. These individuals have an ongoing Special Enrollment Period and can enroll in Part D or change their Part D plan **at any time during the year.**
- ***SEP for Low-Income Subsidy (LIS) Recipients***: Anyone who is a dual eligible automatically gets the full subsidy for prescription costs with Medicare. Otherwise, individuals with limited income and resources who are not getting assistance from Medicaid can apply for the low-income subsidy (also called "extra help") through the Social Security Administration. If someone qualifies for a full or a partial LIS, they have an ongoing Special Enrollment Period and can enroll in Part D or change their Part D plan **at any time during the year.**
- **SEP for Individuals Who Lose the Low-Income Subsidy (LIS):** As a general rule, individuals who qualify for a low-income subsidy, either because they are a dual eligible or because they applied for the subsidy and were approved through SSA, qualify for that subsidy for the remainder of the calendar year. However, in the summer and fall of each year, both Medicare and SSA do redeterminations of subsidy recipients to see if the person still qualifies for the subsidy for the next calendar year. If the person no longer qualifies, he is sent a notice in the fall informing him the subsidy will stop at the end of the year and instructing him that he can re-apply.

  Individuals who lost their LIS as of Jan. 1, 2011 under the redetermination processes get a one-time SEP to drop, join or change their Part D plan. This SEP lasts from J**anuary 1st through March 31st.** Although uncommon, individuals who qualified for the LIS through an application to SSA could lose their subsidy mid-year because of a change in their marital status or because their redetermination was delayed or extended due to an appeal. These individuals qualify for a SEP that **starts the month they were notified of the loss of LIS and lasts for two additional months.** During this SEP, a person can join, drop or change their Part D plan.
- **SEP for Individuals Who Belong to a Qualified State Pharmaceutical Assistance Program (SPAP) or Lose Coverage through an SPAP:** In Pennsylvania, qualified SPAPs include PACE/PACENET, the Chronic Renal Disease Program (CRDP), and the Special Pharmaceutical Benefit Program (SBPB) for people with HIV/AIDS or Schizophrenia. Individuals who receive help through any of these programs can join, change or drop a Part D plan one time during the year outside of the normal enrollment periods. Individuals who no longer qualify for an SPAP can change Part D plans **starting the month they are notified and lasting for two additional months.**

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- **SEP for people who have enrolled in a Part D plan based on misleading information by a plan, agents, or brokers:** Individuals who joined a plan under these circumstances should contact Medicare. Medicare approves this SEP on a case by case basis.

This is **not** an exhaustive list of all the Part D Special Enrollment Periods that exist. Individuals can contact PHLP's Helpline (1-800-274-3258) or APPRISE at 1-800-783-7067 to see if they qualify for any SEP in order to change their Part D plan.

New Federal Poverty Levels in Effect for 2011

New Federal Poverty Levels (FPLs) took effect January 20, 2011 and are a slight increase over the 2010 levels. Below is a brief overview of financial eligibility for health programs that affect older people and use FPLs in determining eligibility. Please note that these figures are what someone must meet ***after*** all deductions and disregards are applied.

Medicaid:

- **Healthy Horizons (also called QMB Plus)-**individuals age 65 and older and persons with permanent disabilities can qualify for this category if they meet the following guidelines:
  Income: $908(single) and $1,226/mo (married)
  Assets: $2,000 (single) and $3,000 (married)
- **Qualified Medicare Beneficiary (QMB)-**helps Medicare beneficiaries with Part A and B cost-sharing as well as the Part B premium:
  Income: $908(single) and $1,226/mo (married)
  Assets: $6,680 (single) and $10,020 (married)
- **Specified Low-Income Medicare Beneficiary (SLMB)-**Helps Medicare beneficiaries pay the Part B premium:
  Income: $1,089 (single) and $1,471/mo (married)
  Assets: $6,680 (single) and $10,020 (married)
- **Qualified Individual-(QI-1)-**Helps Medicare beneficiaries pay the Part B premium:
  Income: $1,226 (single) and $1,656/mo (married)
  Assets: $6,680 (single) and $10,020 (married)

Medicare:

- **Part D Low-Income Subsidy**-Helps Medicare beneficiaries with their Prescription Drug Plan (Part D) costs. Individuals who do not qualify for Medicaid must meet these guidelines:
  Full Subsidy: Income: $1,226 (single) and $1,656/mo (married)
  Assets: $6,680 (single) and $10,020 (married)
  Partial Subsidy: Income: $1,361(single) and $1,839/mo (married)
  Assets: $11,140 (single) and $22,260 (married)

Individuals can contact PHLP's Helpline (1-800-274-3258) for more information about qualifying for these programs.

Applicants for the "Under 60" Waivers Experiencing Significant Delays

PHLP has been contacted by individuals under age 60 who are applying for the Commcare, OBRA, Independence, Attendant Care or AIDS waiver and experiencing significant problems trying to access these programs. Maximus, the new statewide Independent Enrollment Broker for these Home and Community-Based Service (HCBS) programs started operating under its contract with the Office of Long Term Living (OLTL) on December 1, 2010. Maximus is responsible for assisting individuals with applying for any of these waivers after December 1st and guiding the applications through the waiver approval process. Unfortunately, significant delays have occurred in responding to new waiver requests since Maximus started.

According to Maximus' contract with the state, an individual seeking to apply for a waiver should receive an in-home assessment within seven days of contacting Maximus. However, PHLP has learned that some applicants contacting Maximus are being scheduled for an assessment two to three months in the future. When these concerns were raised to OLTL at a recent Medical Assistance Advisory Committee (MAAC) meeting, the state admitted Maximus had insufficient staff to respond timely to the number of calls from new waiver applicants. To remedy the problem, Maximus is increasing its capacity by adding more staff. Once new staff is trained, Maximus will re-contact consumers whose initial appointments were severely delayed and offer them an earlier assessment date. Under this plan, OLTL expects that by mid-March, new callers to Maximus should be scheduled for an in-home assessment within the seven days required by the contract.

Maximus is attempting to prioritize appointments for individuals who are at risk for institutionalization. Currently, "Community Choice" (the expedited process for enrollment into OLTL waivers for at-risk individuals) is available only to individuals residing in these counties: Allegheny, Chester, Cumberland, Dauphin, Delaware, Fayette, Greene, Lancaster, Montgomery, Perry, Philadelphia, and Washington. Under Community Choice, an individual can enroll in an HCBS program within three days of their request if needed. Those who do not reside in a Community Choice county but who are at risk of institutionalization should still make their situation clear to Maximus when calling to apply for a waiver so that Maximus can take steps to expedite the initial assessment.

Individuals interested in applying for one of the waivers listed above should call Maximus at 877-550-4227. PHLP continues to monitor the situation as well as the Office of Long-Term Living's response to the problems identified.

Additional Note: PHLP has also learned that there are over 1,500 people who have applied for one of these waivers **prior** to December 1st and who are still waiting for their application to be processed/approved. These applications are not the responsibility of Maximus; rather, various enrolling agencies across the state are tasked with guiding these applications that were in process before Maximus began its contract. The Consumer Subcommittee of the MAAC and PHLP are urging OLTL to closely monitor these long-pending applications to ensure that they are resolved as quickly as possible.

We encourage individuals who have had difficulties applying for any waiver or who have been experiencing unreasonable delays in the application process to contact our Helpline at 1-800-274-3258 for assistance.

State Decides Not to Pursue Integrated Care Funding

We reported in our December Newsletter that the Pennsylvania Departments of Public Welfare (DPW) and Aging planned to submit a proposal seeking funds from the Centers for Medicare & Medicaid Services (CMS) for short term strategic planning around integrating care for dual eligibles (people who have both Medicare and Medicaid coverage). PA's Office of Long Term Living subsequently shared its draft application for CMS funds with interested stakeholders, and requested input from advocates and organizations across the state.

On February 1, 2011, Acting DPW Secretary Gary Alexander issued a statement notifying stakeholders and others that the state decided not to submit a proposal to CMS to seek funds for an integrated care planning process. Secretary Alexander indicated that the Administration decided not to go forward because it did not want to focus on integrating care only for dual eligibles but would rather look at integrating care and services more broadly across multiple populations and delivery systems.

We will continue to keep our readers updated on any efforts or initiatives put forward by Governor Corbett's administration toward integrating care for seniors and others on Medical Assistance.

Pennsylvania Health Law Project

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