

Presentation by Jeffrey A. Marshall to the Pennsylvania Bar Institute's Elder Law Institute

July 19, 2007

My hope is that this quick overview will provide some context for you as you consider recent developments and trends during the remainder of the Institute.

Again this year, a major area of consternation for seniors and their lawyers is long-term care.

Pennsylvania's Elderly Population Growth

Pennsylvania's demographics create a high demand for long-term care services. Our elderly population is large and growing. We have the third highest proportion of people over the age of 65 among the states.

The greatest need for long-term care services is found among people who are 85 and over. Pennsylvania's elderly population is skewed toward these so-called "old-old." It is projected that our population age 85 and older will grow at the rate of 42% over this current decade, increasing from 238,000 to 338,000 people, while Pennsylvania's overall population will grow only 2%.

Despite this backdrop of an aging population and the spiral of health care and long term care costs, a recent study by John Hancock Insurance showed that Americans are less worried today than they were a decade ago about needing and paying for LTC.

But, I'll tell you who is worried about the cost of long term care: Government. Even though the majority of long term care services are provided at no charge by family and friends of the care recipient, paid services financed with public funds are often eventually needed.

PA Public Funded LTC Programs for Older Adults

Participants: 2004-2005

- | | |
|------------------------------|--------|
| ▪ Aging Waiver | 20,495 |
| ▪ LIFE (national PACE model) | 937 |
| ▪ Nursing Facilities | 81,707 |

Total Medicaid (MA)	103,139
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Total Non-Medicaid	103,452
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(Options, Family Caregiver, SSI Personal Care Home Supp)

Total Public Funded LTC Older Adult Recipients	206,591
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From the chart above, you can see that in 2005 over 200,000 Pennsylvania older adults received publicly funded long term care services. About half of them received Medicaid-funded services, while the other half received services funded solely by the Commonwealth.

This year Pennsylvania expects to expend over \$4 billion in state and federal funds on Medical Assistance benefits for the elderly.

Who Should Pay for Long Term Care?

Who Should Pay for LTC?

Social Insurance?

- The Government should require society at large (taxpayers) to share this risk.

Personal Responsibility?

- The person who needs care should bear the risk and pay the cost.
- Government (taxpayers) should be the last resort.

Getting Alzheimer's, multi-infarct dementia, Parkinson's, having a major stroke, COPD, or other long-term care related illness, is certainly a catastrophic event for the affected individual and family. Should the person who has the misfortune to need long term care pay for that care? Our society has pretty much answered that question yes - the affected individual should only get public funding when their privately available funds are gone.

The problem is, extended long-term care services are expensive. They are a cost for which few private individuals can realistically save. Private funds soon run out.

Should the family of the care dependent person bear the cost of care? Most care-giving services are provided by family members. They bear tremendous financial, physical and emotional burdens.

So, is the need for long term care the kind of catastrophic individual event for which society should provide social insurance? Do we want to provide a foundation of state-funded care for everyone? If so, how do we pay for it? Are we willing to pay for it

through higher taxes or mandated insurance or other contributions?

The current answer from Washington and Harrisburg is NO.

The developments of the past year reflect a political decision that families should bear more of the catastrophic costs of care, and that taxpayers should bear less. We have to help our clients who need long term care deal with the fallout from the decision by both federal and state government to move away from the social insurance model and towards increasing individual responsibility for the cost of long term care.

Many of the developments of the past year represent small steps toward this re-alignment. We do not appear to be willing to make the hard choices needed for fundamental reform of our health care delivery system.

Right now, saving tax dollars seems to be the major impetus driving change. The government is attempting to lower its long-term care expenditures by shifting much of the risk of long-term care away from the taxpayer and onto the person in need of care and that person's family.

So, what is happening is that the long term care delivery system is being tweaked to shift the risk, responsibility, control and burdens of long term care away from the state and onto the individual. The shift is arriving wrapped within positive sounding initiatives like "consumer choice," "expanded options," "nursing facility transitions," "home and community-based care" "consumer direction" and "privatization."

Re-Balancing Long Term Care

Goals

- Shift *Cost Burden* away from Government.
- Increase Personal Responsibility.
- Provide Care in More Desirable Settings.
- Privatize the Delivery of Long Term Care.
- Provide for Quality of Care.

It sounds good. The idea is that we can "re-balance" Medicaid, our main source of public funding for long term care, to pay for less expensive home and community-based care (which people prefer anyway), instead of more expensive nursing home care (which they dread).

How does Government accomplish this re-alignment? These illustrations show some of the methods that Pennsylvania is employing.

These are the bases for the initiatives we are currently seeing.

Re-Balancing Long Term Care

Methods

- Consolidate/Control Public Funding.
- Limit Supply and Demand.
 - *Reduce number of Nursing Facility Beds.*
 - *Make it harder to qualify for Public Funded Care.*

So, the system is being re-balanced, and while this slow moving change may be far from the kind of fundamental social insurance-based re-design many of us would want to see, it is pretty complicated nevertheless.

And while the changes may be gradual, they don't feel that way, if you are the one being "tweaked." For example, the change in the Medicaid transfer penalty is an incremental change, that

is tweaking a lot of us in this room.

Those of us who advise clients who need long term care services should be thinking about the impact the system re-alignment is going to have on this aspect of our practices. This elder law institute is the perfect place to get ideas that can help you adapt your practice to this changing environment.

With that background, let me turn to a discussion of some of the tweaks in long-term care that have occurred over the past year.

Long Term Living Council

In 2006, Governor Rendell changed the management structure which oversees publicly funded long-term care for older adults. To provide overall coordination in a consolidated forum the Governor created the Long Term Living Council. The council brings the

Re-Balancing Long Term Care

Methods, Con't

- Encourage Private Saving for Long Term Care Costs.
- Transition Public Funding From Institutional Care to Lower-Cost Home & Community Based Care.

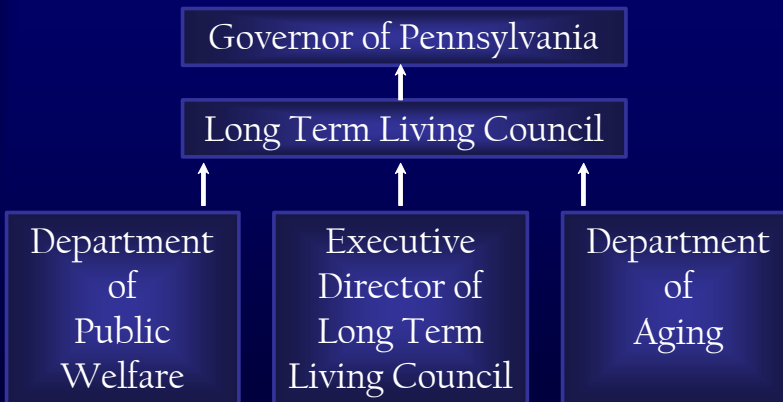
Long Term Living Council Members

- The Secretary of the Department of Aging.
- The Secretary of the Department of Public Welfare.
- The Budget Secretary.
- The Secretary of Policy.
- The Governor's Deputy Chief of Staff.
- The Executive Director of the Office of Health Care Reform.

senior administration officials who focus on long-term care together in a new agency. This illustration shows the resulting new organizational structure for the state agencies that administer Medicaid institutional and home and community waiver programs.

The membership of the Long Term Living Council is comprised of the Governor's key cabinet officers on long term care issues. This includes the Budget Secretary because of the impact long-term care has on the Commonwealth's budget.

Consolidate Public Funding



The importance of the Council is represented by its position above the cabinet departments in this organizational chart.

The Long Term Living Council is tasked with coordinating public funded long-term care across state government departments. Its regular meetings provide a forum for making coordinated policy decisions. Budgetary

implications are a key component of those decisions.

The Executive Director of the Long Term Living Council has overall management responsibility for the coordination of long-term care policy and operations. The Executor director is Mike Hall, a former state official deputy commissioner for health, integrated access and strategy in the Maine Department of Health and Human Services.

Don't underestimate the importance of his role. The assistant Secretaries for the Department of Public Welfare and Department of Aging that deal with long-term care report primarily to him as Executive Director of the Council. The Cabinet Secretaries generally exercise their authority through their membership on the Long Term Living Council.

Limit Supply

One way to limit the cost of long term care is to limit the number of people in high cost nursing homes. There seems no doubt that some nursing home resident's needs could be met in a less costly environment. So, the state is seeking to decrease the supply of nursing home beds, and transition as many nursing home residents as possible to home and community based services.

Limit Demand

There are two major barriers that older adults must surmount to qualify for Medicaid payment of long term care costs:

They must qualify

medically and they must qualify financially. Both of these barriers have been heightened during the last year.

Since the mid-1980s the local Area Agencies on Aging have been in charge of doing Medicaid medical assessments. The local AAAs make the determination as to whether the applicant for long term care benefits needs the level of care required to qualify for Medical Assistance.

Last year, the Department of Aging greatly expanded its supervision of assessment determinations and service plans and sought to centralize the assessment process.

Harrisburg argued that the qualification standards being applied by some local AAAs were too lenient. In truth, the qualification standards were pretty murky and subjective.

In general, individuals with a need for an intermediate level of care, but no need for skilled care, could qualify. The Administration sought to raise the bar by imposing a

Limit Demand

- **Make it harder to qualify for Medicaid/LTC benefits.**
 - **Tighten Medical Qualification Requirements: *The Assessment Process***
 - Centralize/Standardize.
 - Level of Care: Skilled Care vs. Intermediate Care.
 - - APD # 07-01-01 - <http://www.aging.state.pa.us/aging>
 - **Tighten Financial Qualification Requirements: *The DRA***

skilled care requirement - the need for involvement on a regular basis by a skilled medical professional.

On March 28, 2007, the Department of Aging revised its Home and Community Based Services Assessment Manual with the issuance of Aging Program Directive APD # 07-01-01. The APD reflected the tougher "skilled" level of care requirement. (It's Available online at the Department of Aging website <http://www.aging.state.pa.us/aging/>).

The result was that many nursing home residents who had qualified for Medicaid benefits for years, no longer qualified. The Pennsylvania Health Law Project and other advocates began demanding fair hearings on these terminations. There does seem to be a good legal argument that federal law requires the state to qualify individuals even though they need only an intermediate level of care.

Recently, Mike Hall stated that the state is re-evaluating the issue. The bottom line for your clients is - if the skilled care requirement stands, it is going to be much more difficult for them to qualify for Medicaid long term care benefits.

In a related action, the Department of Aging proposed totally removing the long-term care assessment function from the local Area Agencies on Aging (AAAs) and to privatize the assessment function. Secretary of Aging Eisenhower argued that transferring the assessment function to a private enterprise would be more efficient and cost effective, provide for more consistency, and avoid conflicts of interest.

This privatization proposal was opposed by many advocates for the elderly who felt the AAAs would be more attuned and responsive to the varied needs of the older consumers of their communities than would a for-profit managed care company.

More importantly, privatization was strongly opposed by the AAAs themselves. The AAA's have nearly 3,000 employees scattered across Pennsylvania's 67 counties, and close ties to their county commissioners. County Government has historically played a strong role in the local administration and allocation of public resources, including Medicaid. As a result of opposition from County Commissioners and AAA employees, the Administration decided to back off, at least temporarily, from privatizing assessments.

Limit Demand - DRA Implementation

This Spring, while the level of care assessment battles were raging at the Department of Aging, DPW issued its guidance for implementation of the new DRA financial qualification rules. The basic goal of the new DRA rules is to make it more difficult for

applicants to qualify for Medicaid long term care benefits, especially if they have given income or assets away.

DPW decided to implement the DRA by giving informal guidance to CAOs through Operations Memoranda, rather than proceeding through the formal regulatory review process. It is interesting to note that the Governor's Regulatory Agenda suggests that DPW does eventually intend to issue proposed regulations sometime in 2008.

Limit Demand

DRA Implementation in PA

- Operations Memoranda.
- Key Dates:
 - Applications filed on/after March 5, 2007.
 - Transfers made on/after February 8, 2006.
- Transfer Rules: *Two sets of rules to apply – depending on date of transfer*
- Abundance of uncertainty.

In any event, the DRA rules became effective on March 5, 2007 for applications filed on or after that date. The key date for purposes of transfer penalties is February 8, 2006, the effective date of the DRA.

Of course, the DRA changes many rules beyond just transfers. The particulars of the Operations Memoranda are much too complex for me to discuss in this short opening session. If you advise clients regarding qualification for Medical Assistance Long Term care benefits you need to take the time to study each of the memoranda. [The Operations Memoranda are available on the Marshall, Parker & Associates website at http://www.paelderlaw.com/Draft_memos.html.]

It is clear that inter-generational transfers are greatly discouraged by the DRA and the Pennsylvania Operations Memoranda. Giving assets to children or grandchildren is difficult under the new law. On the other hand, there is abundant opportunity to protect the financial security of the community spouse.

The change in the transfer rules represents the biggest “tweak” to affect the traditional elder law practice. If transferring assets from parents to children was the focus of your elder law services in the past, you may want to consider re-focusing for the future.

Assisted Living Residences

In Pennsylvania, assisted living facilities are licensed as personal care homes. State law prohibits most facilities from serving people who need a nursing facility level of care.

This means the state is prevented from using Medicaid home & community based waivers to fund assisted living services.

People who are nursing facility clinically eligible can get Medicaid funded care at home under the Waiver Program, or institutional care in a nursing facility. But Medicaid funded assisted living is unavailable for individuals who are unable to remain in their homes, but who really do not require the intensity of care provided in a nursing home setting.

Re-Balancing Long Term Care

Assisted Living Legislation – SB 704

- Provides for licensing of Assisted Living Residences (ALRs) and distinguishes them from personal care homes.
- Sets the table for Medicaid Funding of ALRs.
- Provides for “informed consent agreements” to reduce liability of providers.
- DPW’s regulations will be key to establishing consumer protections.

As a result, people who could appropriately receive care in a less costly assisted living facility are forced to be institutionalized in a more costly nursing home.

State government has recognized this flaw, and has passed legislation to create a class of assisted living that will be able to accept individuals who

qualify for Medicaid funded nursing home care.

The legislation is Senate Bill 704 which was passed by both houses of the Legislature on Monday (July 16, 2007). SB 704 is controversial, especially for its provision for “informed consent agreements” which will allow facilities to limit their liability for harm to the resident, and for its lack of required consumer protections.

The use of Medicaid funds to shift existing and potential nursing home residents to assisted-living housing is a major element of the re-balancing of long term care delivery in Pennsylvania. Many important details are left to regulations to be issued by DPW. The regulatory process is likely to be long and contentious.

Long Term Care Insurance Partnerships

One way for the state to shift the cost of long term care to the individual is to get people to purchase insurance policies that will pay for needed care.

The DRA gives states the option to enact long-term care insurance partnership programs.

Partnership programs were developed to encourage people who might otherwise turn to Medicaid to finance their long-term care to purchase long term care insurance. When people who have purchased qualifying policies later deplete their insurance benefits, they may then retain a extra amount of assets and still qualify for Medicaid, provided they meet all other Medicaid eligibility criteria.

Earlier this week, the Legislature approved a partnership program this year. SB 548 was the vehicle. [This has now been signed into law by Governor Rendell as Act 40 or 2007].

Unfortunately, it is unlikely that the partnership program will save the state any tax dollars. If you are interested in Partnership policies, you can take a look at a Government Accounting Office Report issued earlier this year. Its title gives you a hint of its conclusions: "*Long Term Care Insurance Partnership Programs: Include Benefits that Protect Policyholders and Are Unlikely to Result in Medicaid Savings.*"

<http://www.gao.gov/new.items/d07231.pdf>

Licensing of Home Care Agencies and Registries

Act 69 of 2006 should be implemented any day now. It requires the licensing of Home Care Agencies and Registries which provide non-medical services to individuals in their homes or other independent living environments. This covers the "Comfort Keepers" and "Home Instead" franchised outfits who directly employ caregivers, and also the so-called "dating services" that put consumers in touch with caregivers who are independent contractors.

The Act calls for background checks, competency training, health screenings, and various consumer protections. It takes effect on publication of the regulations by the Department of Health. A copy of draft regulations is available on the Department of Health website.

PA's new Law on Advance Directives - Act 169

For many years, Pennsylvania was criticized for having inadequate laws regarding advance health care directives, a deficiency that contributes to poor end-of life care. Now the problem has been addressed. Pennsylvania's comprehensive new law governing health care decision making for incompetent adults became effective on January 29, 2007.

The law, Act 169, creates a new chapter 54 of the PEF Code. The law is lengthy and complex.

Act 169 is sweeping in its scope. It covers the most common forms of advance directives, living wills, health care powers of attorney, out of hospital do-not resuscitate

orders and it even touches on the development of the Physician's Order for Life Sustaining Treatment (or POLST). A session on POLST orders is set for this afternoon.

7 key aspects of the new law include:

- (1) Medical decision making by family members and close friends (termed "representatives") is authorized for incompetent adults who have no appointed agent;
- (2) Agents and representatives are given the authority to make almost any decision a competent patient could make;
- (3) The decision making process to be followed by agents and representatives is set out in detail;
- (4) An example advance directive is included. The example form emphasizes that the document is only one step in a planning process that should include frank discussions with family members and health care providers;
- (5) Prior living wills and health care powers of attorney remain valid;
- (6) Responsibilities are placed on physicians and other health care providers;
- (7) The Department of Health is directed to provide oversight to ensure the law's surrogate decision making process is followed.

Act 169 was the result of years of discussion, lobbying, and negotiation by many interest groups. The Act shows the effects of its collective parentage - it is lengthy and intricate and occasionally inconsistent. Unfortunately, this means the law is likely to be either misunderstood or disregarded by many health care providers.

I think the most significant aspect of the new law is the appointment of a default representative for incompetent adults for whom no decision maker is otherwise available. The appointment is made in accordance with the following order of priority:

- (1) The spouse, unless an action for divorce is pending, and the adult children of the principal who are not the children of the spouse.
 - (ii) An adult child.
 - (iii) A parent.
 - (iv) An adult brother or sister.
 - (v) An adult grandchild.
 - (vi) An adult who has knowledge of the principal's preferences and values, including, but not limited to, religious and moral beliefs, to assess how the principal would make health care decisions.

Obviously, there can be more than one member of the class of persons eligible to serve as health care representative. Where agreement is not reached among members of a class: the majority rules. So, your two children by your prior marriage can trump the decision of your current spouse.

Of course, your clients can opt out of the default scheme by appointing their own choice for proxy decision maker.

Here are some additional things to note about the new Chapter 54.

-Old documents are still valid.

-Example form – not required to use it.

- For most people, the health care power of attorney is the tool of choice. Living Wills are very limited.

- Documents alone are not worth much. Conversation is the foundation of effective advance care planning.

If our goal is to help our clients get the care, especially the end of life care, they would desire under unknown future circumstances, then the lawyer needs to do more than just prepare a document.

To enhance our clients' personal autonomy and increase the likelihood that their values will be respected if they become incompetent, we need to help our clients embark upon an advance planning process. We need to emphasize how important it is for them to discuss end-of-life issues with their family members and especially with their designated agent.

An advance directive should assist and supplement those discussions. "Good health care decision-making requires ongoing communication and reflection, before and after an advance directive is executed."

Other Developments of Note

There have been a number of other notable legislative and regulatory changes over the past year.

Other Developments to Note

- **Estate Administration.**
 - Supreme Court adopts uniform filing forms.
- **Medicaid.**
 - DPW fails to increase Penalty Divisor on July 1.
- **New Funeral Director Misconduct Regulations.**
 - 49 PA. CODE CH. 13 §13.202.

