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### Colliton Law Associates, P.C.

**Janet M. Colliton, Esq.**  
790 E. Market St., Ste. 250  
West Chester, PA 19382-4806

Telephone: (610) 436-6674  
Fax: (610) 738-9305  
e-mail: colliton@collitonlaw.com

*Brady*

August 27, 2005

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DEPARTMENT OF PUBLIC WELFARE  
OFFICE OF MEDICAL ASSISTANCE PROGRAMS  
ATTN: REGULATIONS COORDINATOR / ROOM 515  
HEALTH AND WELFARE BUILDING  
HARRISBURG, PA 17105

**RE: PA. BULLETIN DOC. NO. 05-1435**  
**NURSING FACILITY SERVICES; PREADMISSION REQUIREMENTS**  
**and CIVIL RIGHTS COMPLIANCE FOR NURSING FACILITIES**

**COMMENTS**

Gentlemen/Ladies:

*The within are Comments relative to Proposed Rulemaking, Department of Public Welfare to amend Chapter 1187 relating to nursing facility services, which comments are due to be submitted by August 30, 2005.*

**It is requested that these Comments be accepted as part of the record and considered by the Department as follows:**

**I. BACKGROUND:**

The undersigned is an elder law attorney in the Commonwealth of Pennsylvania. I have practiced law in the Commonwealth for the past 28 years and have practiced elder law intensively for the past 8 years. I am a member of the Chester County Elder Law Section (Section Chair) and of the Pennsylvania Bar Association Elder Law Section and the National Academy of Elder Law Attorneys (NAELA). I am a former First Assistant County Solicitor, Chester County, Pennsylvania, and, in that capacity, supervised attorneys who directly represented Chester County Department of Aging (formerly "Senior Citizens") and the County Department of Mental Health/ Mental Retardation.

In the course of my private practice I meet with hundreds of families whose family

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**Colliton Law Associates, PC**  
**Comments – Dept. of Public Welfare**  
**Proposed Rulemaking**  
**Pa. Bulletin, Doc. No. 05-1435**  
**PAGE 2**

member, usually a person over age 65, suffers from a disability. Many of these persons, who are the spouses or parents of the person who seeks my advice, either are currently on Pennsylvania Medical Assistance or may reasonably be expected to receive Medical Assistance within a period from as little as one month (Medicaid pending) to several years during which time such families are paying privately for skilled care or for home based care. In the course of the last 8 years, I estimate that I have met with, advised or discussed Medical Assistance with well over 500 families. My practice is focused primarily in Chester County, Pennsylvania and in the surrounding Philadelphia suburban counties.

**II. REQUESTED ACTION:**

For the reasons detailed in these comments, I am requesting that the Regulation in question be ***withdrawn and reconsidered*** pending such time when satisfactory resolution of the issues raised by these comments can be achieved, assuming that this can be done.

**III. THE REGULATION – STATEMENT AND ANALYSIS.**

1. **Stated Purpose:** The Regulation under consideration states as its purpose that it “requires a nursing facility to have applicants evaluated by the Department or its independent assessor for the need for nursing facility services *prior to admission* to the facility. The clinical evaluation is intended not only to determine an individual’s need for nursing facility services, but also to educate the individual regarding other available long-term care service options. *The Department expects that when given the information necessary to make an informed choice, more individuals will choose to receive home and community-based services (HCBS) as opposed to institutional services.*” (Emphasis added). See Regulation “Purpose” at page 1. It would appear from this description that the Regulation has a benign intent of assuring that those who receive services are qualified and that they are provided information. For reasons stated in these comments, such description does not appear to clearly reflect the intent.

**Colliton Law Associates, PC**  
**Comments – Dept. of Public Welfare**  
**Proposed Rulemaking**  
**Pa. Bulletin, Doc. No. 05-1435**  
**PAGE 3**

In the event that the Regulation is disregarded, the penalties against a skilled nursing facility for non-compliance in ordering and completing such “clinical evaluation” *in advance of admission* to a facility are extreme and range from a minimum of \$150 per day to a maximum of \$3,000 per day but in any event not less than the nursing facility’s total aggregate charges to the individual for services rendered during a period of non-compliance. In other words, the facility would, at minimum, be denied the ability to obtain reimbursement from the Commonwealth for the cost of care for the individual. At maximum, its civil penalty could be as high as \$93,000 per month per patient (\$1,095,000 per year *per patient* admitted in violation of the Regulation.)

2. **Timing of the Evaluation hinders compliance and may act as a roadblock to admitting any MA applicants to skilled nursing care** - The evaluation under the Proposed Regulation must not only be requested *but also completed* by the Department or its representative (AAA) prior to admission to the facility. There are exceptions to the completion requirement noted at Subchapter D., Section 1187.31 (2) (ii). These exceptions relate primarily to the circumstance where the <prospective> resident **will not receive Medical Assistance**. The single exception to this is under proposed 1187.31 (ii)(A)(II) for emergencies under the Older Adult Protective Services Law.

As to those persons who are considered “MA applicants” and either have “submitted an application for MA nursing facility services” or, based upon financial information provided are “likely to be an MA conversion resident within 12 months from the date of admission” the nursing home may disregard the advance requirement and admit *only* under the following circumstances: (I) The

**Colliton Law Associates, PC**  
**Comments – Dept. of Public Welfare**  
**Proposed Rulemaking**  
**Pa. Bulletin, Doc. No. 05-1435**  
**PAGE 4**

nursing facility refers the applicant for a clinical evaluation prior to admission <and> (II) The applicant provides the Department or its independent assessor with the information necessary to conduct the evaluation <and> (III) The Department or its independent assessor *notifies* the referring nursing facility that it has received the information necessary to conduct the evaluation <and> (IV) The Department or its independent assessor does not complete the evaluation after receipt of the information and allowing three working days if the individual is a patient in a hospital, five working days if the individual is in a community setting, or ten working days if the individual is a resident of another nursing facility. Proposed Section 1187.31(2)(ii)(III).

First, it should be noted that **an evaluation (Options Assessment) is currently required before an Applicant may receive Medical Assistance to pay for skilled nursing care.** The question, as to medical evaluation, therefore, is whether the medical evaluation must be completed *before admission* to the facility. In other words, the question is whether the Options Assessment may be made a further stumbling block to admission to skilled care. Many Options Assessments today are completed after admission to a facility but well before Medical Assistance would apply.

There is a backlog of evaluations now by Departments of Aging in some counties that can run several weeks. An informal inquiry made by the undersigned to one person associated with a County Department of Aging would indicate that Departments of Aging who will be expected to conduct this advance review may not have been notified of these responsibilities associated with the Regulation.

It is noted also that, in order for a facility to determine whether an Applicant might receive Medical Assistance within one year of admission (and, therefore, be considered a “Medicaid Applicant”), the facility will also have to have received

**Colliton Law Associates, PC**  
**Comments – Dept. of Public Welfare**  
**Proposed Rulemaking**  
**Pa. Bulletin, Doc. No. 05-1435**  
**PAGE 5**

reliable information from the family of the state of the Applicant's assets before admission with attendant further delays. In the area of the State where I practice, the average cost of skilled nursing care approximates \$7,000 per month in addition to the cost of prescription medicines and other incidentals. An applicant with liquid assets slightly less than \$100,000 might reasonably be considered to be a "Medicaid Applicant" within the definition provided.

In brief, the procedure described would, at minimum, extend the time before persons who require services could be admitted. However, the more likely result is that it will act as at least a further disincentive to skilled nursing facilities to admit Medical Assistance residents and a hindrance to admission for seriously disabled persons while advancing on the waiting list for admission those persons who are not and who would not become MA recipients. By placing MA patients even further behind those who pay privately, the Regulation would discriminate in the provision of care against MA patients.

3. ***The Proposed Regulation Requires a "Clinical Evaluation" Only of MA <Prospective> Applicants and MA Recipients and not of other persons and, therefore, unlawfully discriminates against MA Applicants and MA Recipients in the Availability, Accessibility and Provision of Skilled Nursing Care.***

The "Purpose" preamble to the Regulation states that the "clinical evaluation" is also intended to "education MA Applicants and MA Recipients regarding "other available long-term care service options."

"Nursing facility applicants" as defined in the regulation *who are not MA Applicants or MA Recipients* are only required to be prescreened under the provisions of federal law. *Persons who are not considered to be at risk of going on Medical Assistance are not required to be advised that there are "other available long-term care service options."* In other words, **only** MA Recipients and MA Applicants are to be advised that there are services available at home.

**Colliton Law Associates, PC**  
**Comments – Dept. of Public Welfare**  
**Proposed Rulemaking**  
**Pa. Bulletin, Doc. No. 05-1435**  
**PAGE 6**

If the function was intended to be an educational function to advise persons entering skilled care that adequate care is available in the community, then it would follow naturally that everyone should receive this information. Instead only MA Applicants and MA Recipients are required to be so advised.

It is obvious that the reason for the instruction to MA admittees is to discourage them from obtaining skilled nursing care. In fact, the “Purpose” preamble to the Regulation states that this is true. The motivation is blatantly financial. It is submitted that the regulation is discriminatory under the Americans With Disabilities Act and also under federal laws and regulations regulating the provision of skilled nursing services.

Persons in a Medicaid certified skilled nursing care setting receive an entitlement to services when they are medically and financially eligible. Persons at home do not have such entitlement. Even though fully qualified medically and financially, they may wait months or years or never receive at-home services because there is no entitlement.

In order to make an “informed choice,” prospective MA recipients and MA applicants would have to be advised at minimum that, in a skilled nursing environment, when eligible to receive services, they would be received whereas, at-home services might or might not be provided.

4. **The Proposed Regulation Would Require AAA Representatives to Advise That Long-Term Care Service Options Are Available Outside Skilled Care Without Indicating Whether These Services Are, Practically Speaking, Available to the Applicant or Whether They Would Fill the Applicant’s Needs.**

The theoretical availability of services is not the same as the actual provision of services to the applicant.

**Colliton Law Associates, PC**  
**Comments – Dept. of Public Welfare**  
**Proposed Rulemaking**  
**Pa. Bulletin, Doc. No. 05-1435**  
**PAGE 7**

The same “education” that services are available at home under the Regulation would be given to persons who are stroke victims, MS patients, Parkinson’s patients, persons with Alzheimer’s, dementia and diminished capacity, diabetics, brain injured, amputees, cardiac patients and persons with innumerable physical incapacities. The programs that are available are not available equally to all segments of the population and many Pennsylvania at-home programs are not available to persons over age 59 or 60. In addition, the persons who would be instructing persons that they should seek at-home services instead of skilled care services generally *are not medically qualified* to determine what specific services should be provided.

Pennsylvania has the second largest percentage of elder population in the country. It has been described as 48<sup>th</sup> of 50 States in the provision of government-funded at-home care.

In my own County, in the past 8 years of intensive practice in elder law and after speaking to and dealing with hundreds of families, I have never met anyone who received at-home services under the Pennsylvania Department of Aging Home and Community Based Waiver Program (PDA Waiver) which is the primary at-home Pennsylvania care program for seniors. In this past week, I spoke to one person whose family member has been receiving PDA Waiver services in Chester County. She called because those services were at risk of termination. I spoke to one family member in a neighboring county whose father-in-law, received services under PDA Waiver. This was after an application process that took 26 months and constant intervention by the family to move the application along.

The Bridge Program which is considered the next most available program in Pennsylvania *was totally eliminated* a month ago with the Pennsylvania budget cuts.

**Colliton Law Associates, PC**  
**Comments – Dept. of Public Welfare**  
**Proposed Rulemaking**  
**Pa. Bulletin, Doc. No. 05-1435**  
**PAGE 8**

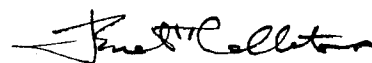
The Family Caregiver Support Program provides some financial assistance for Adult Care which is not applicable in most instances where family members need to transition to skilled care. Meals on Wheels and similar services do not deal with medical issues.

In a report by the Pennsylvania Intra-Governmental Council on Long-Term Care, the “Home and Community-Based Services Barriers Elimination Work Group Report,” submitted to the Governor in March, 2002 and available publicly at [www.aging.state.pa.us/aging/lib/aging/BarriersEliminationReport.pdf](http://www.aging.state.pa.us/aging/lib/aging/BarriersEliminationReport.pdf), the Council described 22 Barriers to Home and Community-Based Services in Pennsylvania, the majority of which still apply to services for the aging and to services in the area of the State where I practice.

There cannot be an “informed choice” where representatives of the Department charged with informing physically and mentally infirm applicants have not adequately advised (1) the government might not and need not provide services at-home; (2) the wait for services in one’s home may take several months or years if received at all; (3) the suburban and rural counties may not have service providers available to provide needed services; (4) if service providers are available at this time, they may not be available in the future; (5) the applicant must submit detailed records to qualify; (6) the applicant, if in a hospital at the time of the interview, may enter skilled nursing care for rehabilitation on the Medicare program after three continuous days of hospitalization where his or her care may be covered. However, if the applicant leaves the hospital to return home, he will lose this ability and must pay privately.

The Regulation encourages persons who are at the most vulnerable stage of their lives to forego care to which they are rightfully entitled under federal law. It discriminates against Medicaid patients and is, therefore, in violation of the law and should be withdrawn.

Respectfully submitted,  
COLLITON LAW ASSOCIATES, PC



JANET M. COLLITON

JMC/bms