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"The future of long term care"
PHCA
PENNSYLVANIA HEALTH CARE ASSOCIATION

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August 29, 2005

Via Hand Delivery and Regular Mail

Department of Public Welfare
Office of Medical Assistance Programs
ATTN: Regulatory Coordinator
Room 515, Health and Welfare Building
Harrisburg, PA 17105

Re: Comments of Proposed Rulemaking

Dear Sir or Madam:

On behalf of the roughly 300 members of the Pennsylvania Health Care Association ("PHCA"), I offer comments on the Notice of Proposed Rulemaking the Department published in the Pennsylvania Bulletin on July 30, 2005 concerning changes to clinical preadmission evaluations of nursing home applicants and to civil rights data collection and reporting requirements. PHCA represents the full continuum of long term care and service providers, including continuing care retirement communities, nursing homes, assisted living residences, personal care homes, and home health care, therapy and hospice services. The overwhelming majority of our nursing home members participate in the Medicaid program and bear a disproportionate share of the Medicaid load when compared to other nursing homes in the Commonwealth.

We strongly oppose the proposed changes to clinical preadmission requirements and have serious reservations concerning the civil rights data collection and reporting requirements. We also believe additional clarification is essential in both arenas. We will address each arena separately.

Proposed Changes to Clinical Preadmission Requirements

First, we question the legality of the preadmission requirements as they pertain to individuals who will not be eligible for Medicaid at the time of their admission to nursing homes. While we understand that the Department has the legal authority to impose such requirements on "first day Medicaid eligibles," we do not believe that such authority extends to individuals who may become eligible within 12 months of admission to a nursing home.

Second, we believe that the effect of the proposed preadmission requirements, when contrasted with the streamlined process for both clinical and financial eligibility determinations the Department affords to those seeking placement in Medicaid-funded home-and-community-based

services ("HCBS"), actually is contrary to the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999). In Olmstead, the majority clearly held that a state must make facility-based care and HCBS equally available to eligible individuals, and specifically stated that a state may not restrict access to facility-based care for those who prefer such settings.

Currently, individuals seeking admission to nursing homes may be admitted pending completion of the OPTIONS evaluation by the Area Agency on Aging to establish clinical eligibility and pending a determination by the County Assistance Office ("CAO") to establish financial eligibility. While every effort is made to complete the OPTIONS assessment before admission, admission is not delayed or deferred pending completion, which typically occurs soon after admission. If an individual admitted pending completion of the application proves clinically ineligible, of course, the Department is not obligated to make any Medicaid payments for care and services rendered by the nursing home.

Department regulations require that the CAOs make financial eligibility determinations within 30 days following admission, although this requirement frequently is honored in the breach, such that our members routinely do not receive financial eligibility determinations for 45-60 days following admission. As a consequence, at the time of financial eligibility determinations, the Department routinely owes nursing homes tens of thousands of dollars in outstanding receivables for services already rendered.

By contrast, the recently created Community Choice program effectively establishes presumptive clinical and financial eligibility for individuals seeking Medicaid-funded HCBS. The form used to determine clinical eligibility for Medicaid-funded HCBS is four pages. The form used to determine clinical eligibility for nursing home care is twelve pages. **The clinical eligibility standards, however, are identical regardless of setting.** The Community Choice program allows financial eligibility determinations to be made swiftly, and based solely on the information the applicant provides at time of admission. Given the recent legislative amendments to the Public Welfare Code and the recent regulatory changes the Department adopted in implementing Community Choice that establish substantially similar financial eligibility criteria for nursing homes and HCBS, once again the basis for establishing financial eligibility is essentially identical regardless of care setting. In addition, Community Choice requires that clinical and eligibility determinations must be made in as little as 24 hours **if necessary to avoid nursing home placement.** For nursing homes, such determinations take substantially longer.

Before considering the proposed regulatory amendments, therefore, the Department's disparate treatment of individuals seeking nursing home placement and individuals seeking HCBS placement seems inconsistent with the Olmstead requirement that a state not treat different groups within a protected class differently and, in particular, that a state place no greater obstacles in the way of individuals who seek or require facility placement than those who seek or require HCBS placement. The proposed amendments exacerbate this inconsistency by widening the gap between the manner in which these groups are treated.

In particular, the proposed regulations appear to bar the current practice of admitting residents pending completion of the OPTIONS assessment, and with all financial risk borne by the provider, for individuals likely to qualify as "first day Medicaid eligibles." The proposed regulations also extend this bar to individuals who may become financially eligible within 12 months of nursing home admission. In both cases, moreover, the Department will have from three to ten "working days" within which to determine clinical eligibility for nursing home admissions, depending on the current location of the prospective nursing home resident. By contrast, such decisions with respect to HCBS placement, based on the same evaluative criteria, must be made within 24 hours. There is little doubt that these differing requirements for distinct subgroups within the protected class of disabled individuals seeking long term care services under Medicaid directly contradicts the Supreme Court's holding in Olmstead.

Third, we believe that key assumptions underlying the purpose of and need for these proposed regulations are flawed. The preamble accompanying the proposed regulations implies that: (1) these changes are required legally; (2) they will provide more consumers with better information thereby responding more effectively to consumer preferences; (3) providing information concerning long term care options to a broader array of those eligible for nursing home care will lead to greater use of HCBS alternatives and a concomitant decrease in nursing home use; and (4) as a result, overall Medicaid long term care expenditures will be lower than they otherwise would have been. Each of these assumptions is inaccurate and therefore the rationale underlying the proposed changes is invalid.

The preamble references the Olmstead decision, and the federal government's guidance in the wake of the decision suggesting that the greater the number of those eligible for Medicaid-funded long term care receiving services in HCBS settings, the greater the "compliance" with Olmstead, to conclude that a preadmissions screening process designed to deter the use of nursing homes either is required by Olmstead or otherwise demonstrates greater compliance with the decision. As explained above, this seems to contravene directly the court's decision. In addition, it represents an incomplete reading of the decision. The Olmstead court clearly noted that, while states should strive to assure that services are provided in settings appropriate to the needs of each individual, states may not make access to one type of services (e.g., nursing home care) more difficult than another type of service (e.g., HCBS). The court also recognized that legitimate state interests, including an undue cost burden, justify appropriate limitations on access to HCBS.

If expansion of Medicaid-funded HCBS is the goal of the proposed regulations, we respectfully submit that the Department does not need these regulations to advance its objective. In recent years, Pennsylvania has expanded access to Medicaid-funded HCBS substantially. The Department itself claims that use of Medicaid-funded HCBS grew by approximately 30% in the last two years, and the Commonwealth's budget for the 2005-06 fiscal year contemplates continuing expansion. Indeed, according to recent national research, Pennsylvania spent more than $1.3 billion on Medicaid-funded HCBS in FY 2004.[1] The Community Choice program,

[1] Thompson/Medstat, Medicaid Long Term Care Expenditures in FY 2005 (May 11, 2005).

which effectively creates presumptive eligibility for Medicaid-funded HCBS, appears to have achieved the Department's objective, such that the proposed regulations regarding preadmission clinical eligibility determinations become unnecessary.

The Department also contends that consumer preferences justify the proposed regulations, particularly because more people will receive information about options and alternatives to nursing homes than currently receive such information. This claim borders on the disingenuous, given the substantial number of government resources available to all consumers in general and to Medicaid beneficiaries in particular. The Area Agencies on Aging, the Pennsylvania Department of Aging, the Community Choice Program and the Department itself already provide detailed information on long term care choices to a wide array of consumers in a variety of settings, and most of these materials place substantial emphasis on HCBS alternatives to nursing home care. Accordingly, this rationale for the proposed regulations is inapt.

In addition, the Department chooses selectively from consumer preferences in proposing policy change, thereby ignoring preferences with regard to nursing home care and services. When asked, the most significant objections consumers voice concern the lack of privacy (e.g., double rooms and shared baths) and the "institutional" setting. Ironically, both are the result of government policy. Department of Health licensure requirements and Medicare and Medicaid certification requirements mandate that nursing homes meet institutional construction standards. Medicare and Medicaid payment policies will not cover the additional costs of private rooms. Medicare and Medicaid capital payment policies prevent facilities from obtaining the capital necessary to modernize current capacity. The Department's moratorium on certified beds and the transfer or sale of certified beds adds even greater market constraints on modernization and consumer responsiveness. Consequently, the proposed regulations ignore substantial policy changes that also would respond to consumer preferences in a manner that could revitalize the 630 nursing homes currently participating in the Commonwealth's Medicaid program and also could accelerate appropriate expansion of Medicaid-funded HCBS.

Finally, the Department asserts that the proposed regulations will shift the locus of Medicaid-funded care and services from nursing homes to HCBS settings, thereby reducing overall costs to the Medicaid program. In fact, the simplistic cost comparisons offered in the preamble are suspect and a growing body of evidence suggests that, quite to the contrary, Medicaid-funded HCBS programs increase overall Medicaid costs.

While there is no doubt that the average Medicaid cost per beneficiary is less for HCBS than for nursing home care, nursing home residents generally require much more intensive and costly services than Medicaid beneficiaries receiving care and services in the community. It is no accident that, as more Medicaid beneficiaries receive HCBS, the acuity levels for Medicaid recipients in nursing home residents increases as well. We certainly have witnessed this phenomenon in Pennsylvania. For example, in developing its proposed budget for FY 2005-06, the Governor's Budget Office estimated that nursing home acuity would increase 0.5% during the fiscal year. The Department's more recent projections this month have increased this estimate to more than 0.8%. A reasonable explanation for this growth in acuity is the 30%

expansion of Medicaid-funded HCBS services the Commonwealth has experienced in the last two years.

It is worth noting, moreover, that, in the face of substantial Medicaid-funded HCBS expansion, nursing home occupancy rates in Pennsylvania have increased almost 3% in recent years, such that statewide occupancy is 91%. In addition, Medicaid occupancy has increased roughly 1% over the same period, such that 67% of nursing home residents qualify for the program. The only reasonable inference, therefore, is that HCBS expansion has **not** become a substitute for nursing home care. With respect to the Medicaid budget, this means that: (1) HCBS services are largely additive; and (2) the expansion of HCBS means that those in nursing homes are sicker and therefore more expensive to treat.

We also believe that, by evaluating only Medicaid expenditures, rather than overall government expenditures, cost comparisons do not reasonably reflect the potential impact on the state budget. As you know, nursing home care includes 24-hour-a-day, 7-day-a-week, 265-days-a-year access to health care, nursing care, social and supportive services, activities and room and board. All of these are included in the daily Medicaid payment rate. By contrast, Medicaid-funded HCBS pays for only a fraction of these services and does not afford round-the-clock care and services. In many cases, however, those receiving Medicaid-funded HCBS also receive support through other government programs administered outside the Department. Unless the Department compares the total cost to the state in providing care in HCBS settings, it does not offer a complete picture of the financial impact of its policies.

Accordingly, the budgetary assumptions underlying the proposed regulation seem patently false, such that they do not form a legitimate basis for the proposed changes. Indeed, given that HCBS expansion seems to add to the Commonwealth's Medicaid burden and overall financial burden, the Olmstead decision offers clear legal justification for slowing, rather than accelerating, the expansion of Medicaid-funded HCBS in Pennsylvania.

With these global comments and our overall opposition to the clinical preadmission requirements clearly stated, we also have comments and questions regarding the specific regulatory provisions, as follows:

1. **The Department should continue to allow admissions pending completion of the OPTIONS assessment.** As mentioned earlier, under current interpretation of existing regulations, the Area Agencies on Aging sometimes complete the OPTIONS assessment after admission under broader criteria than the exceptions in the proposed rule. We strongly urge the Department to allow such practices to continue not only for "first day Medicaid eligibles," but also for any other individuals for whom the regulations require completion of the OPTIONS assessment or any other preadmission clinical assessment.

2. **The Department should incorporate the assessments referenced in the proposed regulations into the OPTIONS assessment process, rather than creating a separate assessment process.** We strongly urge the Department to use the existing OPTIONS

process administered through the Area Agencies on Aging. Such an approach will allow streamlined administrative processing, such that nursing homes and other providers will not be required to work with multiple agencies for different assessments. We are especially concerned that the Department will elect to subcontract with private third parties, particularly advocacy groups. When government agencies have done so in recent years, advocacy groups have been unable to distinguish between their responsibilities as agents of the Commonwealth and their private interests as consumer advocates. Indeed, in recent months such an advocacy agency, purportedly acting under its grant of authority from the Administration, elected to occupy a nursing home. The result was the removal of these "government agents" by the State Police. It would be quite inappropriate for the Department to contract with such third parties to conduct such assessments.

3. **The Department should adopt substantially similar processes and timeframes for determining financial and clinical eligibility for both nursing home and HCBS placement.** We strongly urge the Department to adopt substantially similar, if not identical, processes for clinical and financial eligibility determinations, regardless of care setting. The streamlined assessment process used under the Community Choice program apparently has proven quite effective. Accordingly, there is no legitimate reason that the same process cannot be extended to nursing home placements, and the proposed regulations should be modified to assure such uniformity. For example, there is no reason that the Department should require a 12-page clinical eligibility form for nursing home placement and a 4-page clinical eligibility form for HCBS placement when the clinical eligibility requirements are identical regardless of site. Similarly, since financial eligibility standards now are virtually identical regardless of placement, there is no justification for presumptive eligibility for HCBS, while nursing homes must wait 30 days or longer for financial eligibility determinations.

   Frankly, the time frames set forth in section 1187.31(ii)(B)(IV) simply are too long in any event. They will create backlogs for hospital discharges and could put individuals seeking nursing home care at substantial risk, particularly those residing in the community or in personal care homes. These risks become particularly apparent when contrasted with the Community Choice requirement that the Department make identical decisions regarding HCBS placement within 24 hours.

4. **The Department should substantially reduce or eliminate the penalty provisions.** If nursing homes mistakenly admit residents that are not clinically or financially eligible for nursing home placement, then the Department need not make payments under the Medicaid program. If the Department has made payments improperly, than the Department may recoup such payments under existing authority. The additional penalties, including civil monetary penalties, are unnecessary and add no incentives to encourage compliance by nursing homes. The penalty provisions, however, do authorize the Department to impose sanctions when a nursing home, in good faith, admits a resident who seeks such placement and whom the facility believes will not qualify for Medicaid within 12 months if the Department concludes otherwise with respect to

financial eligibility. Such a possibility is highly inappropriate, particularly since it interferes with the individual's right to seek nursing home placement, whether the payer source is private or public.

5. **The Department should specify the manner in which nursing homes seek information to determine whether an applicant is likely to convert to Medicaid within 12 months of admission.** The proposed regulations apparently require that nursing homes determine whether an applicant for admission might become financially eligible for Medicaid within 12 months. While nursing homes currently may request financial information from applications prior to admission, the applicants are under no obligation to provide such information, nor is the facility required to request information sufficient to determine whether an individual might become Medicaid-eligible within 12 months. Absent clear guidance from the Department through regulation, nursing homes will be at risk for a finding that they did not inquire properly or adequately at time of admission and they therefore could be subject to the penalties described in the proposed regulations. The regulations, therefore, should clearly specify the manner in which facilities are expected to determine potential Medicaid eligibility and also should contain an exemption from penalties for facilities that act in good faith in making such determinations.

6. **The proposed regulations do not acknowledge current nursing home operational practices and would require substantial and unwarranted changes in nursing home operations.** Nursing homes typically receive requests for admissions twenty-four hours a day, seven days a week and three hundred and sixty-five days a year. Inquiries often come directly from hospitals, and nursing homes must make admission decisions immediately, and then complete appropriate paperwork - - from applications to obtaining financial information to coordinating OPTIONS evaluation - - after admission. The proposed regulations essentially would halt this flow of operations, since nursing homes would not be able to admit residents who are Medicaid-eligible or who might become Medicaid-eligible within 12 months until the Department's evaluation had been completed. The proposed regulations, moreover, give the Department at least 3 working days and as long as 10 working days to complete its preadmission assessment. Such a dramatic change in practice would affect all aspects of facility operations and would put at risk those who require more immediate nursing home care. Frankly, there are a substantial number of individuals admitted to nursing homes each day, including those eligible for Medicaid, who cannot safely and reasonably receive care in HCBS settings, yet the proposed regulations would require either that such individuals remain inappropriately in hospitals, with the hospitals bearing the costs of care, or that they remain inappropriately at home or in the community where their needs cannot be met.

7. **The proposed regulations will impose substantial costs on nursing homes that will not be subject to recoupment.** The costs of compliance with the proposed regulations would be enormous. Nursing homes would be required to redesign policies and procedures, as well as forms and internal protocols. Facilities also would face cash flow

challenges since they would not be able to make rapid admission decisions in the face of empty nursing home beds. Nursing homes will have limited opportunities to transfer these additional costs to payers. For the 20% of nursing home residents who pay privately, it is difficult to increase rates to cover cost increases, and extremely difficult to increase prices to take into account costs imposed on residents with other payer sources. For the 10-15% of residents on Medicare, that program will not provide any compensation for additional costs incurred in complying with the proposed regulations. For the 66% of residents on Medicaid, compliance costs are likely to be considered general and administrative expenses, which are capped under the current payment system. Since at least 75% of nursing homes have general and administrative expenses in excess of the cap, they would receive no additional reimbursement whatsoever for such additional costs. This is a particularly onerous burden, given that the Department is in the process of reducing Medicaid payments to nursing facilities as it implements the budget for fiscal year 2005-06.

In conclusion, we urge the Department to withdraw or substantially revamp the proposed changes in clinical preadmission requirements. These proposed changes appear to be inconsistent with the Olmstead decision, to discriminate against those individuals who require and prefer nursing home care, to be based on inaccurate assumptions, to threaten timely access to nursing home care for many who clearly require such services, to undermine the current delicate balance between hospital discharges and nursing home admissions, to substantially disrupt nursing home operations and to make no accommodations for the increased costs nursing homes must bear. We believe that a much more reasonable and equitable approach would be to extend the streamlined clinical and financial eligibility determination processes currently available to consumers seeking Medicaid-funded HCBS to those seeking nursing home placement as well.

Proposed Civil Rights Data Collection and Reporting Requirements

We also have substantial concerns regarding the civil rights data collections and reporting requirements specified in the proposed regulation. Our comments in this regard are more specific than with regard to the clinical preadmission requirements, as follows:

1. **The Department should clarify that, while nursing homes may seek specified information from applicants, those applicants are not required to provide such information.** The proposed regulations require facilities to collect information regarding age and race or ethnicity, but to provide information regarding religion only if "volunteered and used as a factor in admission." While the Department may require that facilities ask for such information, clearly applicants are under no legal obligation to provide information regarding age, race ethnicity or religion. Accordingly, the regulations should clarify that, while nursing homes must ask for this information, they will not be subject to sanction if, despite their good faith efforts, applicants chose not to provide such information. Indeed, the regulations should specify in particular that nursing homes may inform applicants that the government requires that nursing homes

ask each applicant such questions but that the applicant has the right to refuse to answer, with the proviso that failure to answer could jeopardize access to payment programs under certain circumstances (e.g., for government programs like Medicare that have age qualifications).

2. **The Department should define the phrase "disposition of the application."** The proposed regulation uses this phrase repeatedly, yet it is not a term of art in nursing home practice. Accordingly, we recommend that the Department define the term in the regulation.

3. **The Department should conform retention of civil rights records to other provisions regarding retention of records.** The proposed regulations require that the facility retain records for four years. Given that the data must be reported to the Department at intervals to be specified, there appears to be no reason that the facility must retain the records for any given period. Accordingly, we recommend that the regulations require that facilities retain reports consistent with their respective internal record retention protocols.

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Thank you for the opportunity to comment on the proposed regulations. If you have questions, please feel free to contact me.

Very truly yours,

Alan G. Rosenbloom
President and CEO

AGR/jlh

cc: Honorable Jake Corman
Honorable Vincent J. Hughes
Honorable George T. Kenney, Jr.
Honorable Frank L. Oliver
John R. McGinley, Jr., Esq.