Original: 2488

14-493-12

PCA
PHILADELPHIA CORPORATION FOR AGING™
Enriching lives, preserving dignity.

RECEIVED
05 SEP 12 PM 3:18
OFFICE OF LTC PGMS
REFER TO Gail

DEPUTY SECRETARY
OFFICE OF M.A. PROGRAMS
EPW

2005 SEP -8 P 12:24

REFER TO Bradley

September 6, 2005

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

SEP 13 2005
cc: PAR FAAD Jim Lee

RECEIVED
SEP 13 2005
PROGRAM ANALYSIS
AND REVIEW SECTION

Dear Regulations Coordinator:

Thank you for the opportunity to respond to the proposed changes to 55 Code Chapter 1187 regarding preadmission requirements for Nursing Facilities.

Philadelphia Corporation for Aging is unconditionally committed to ensuring each and every consumer has the opportunity to make an informed decision regarding home and community based care prior to entering a Nursing Facility. Accordingly, PCA wholeheartedly supports the requirement of a comprehensive assessment prior to admission for any consumer who will spend down to MA eligibility within their first 12 months of Nursing Home placement.

Current regulations require a preadmission assessment for consumers who will spend down to MA eligibility within their first 3 months of placement. This regulation has, unfortunately, not been enforced. Consumers are frequently placed in Nursing Facilities and PCA is contacted after admission or after death or discharge. Hospital discharge planners and Nursing Home admission staff need to be educated regarding the availability of home and community services, as well as the monetary penalities in the Pennsylvania Code. PCA will be happy to assist with and provide a venue for educational sessions for discharge and admission staff.

As previously mentioned, PCA strongly believes in giving people options regarding their long term care needs, primarily home and community based care. PCA currently has a waiting list for services of 308 Nursing Facility Clinically Eligible who are not MA eligible. With the closure of the Bridge Program, in order to truly be able to divert this population we need additional state funds through our block grant with PDA, primarily lottery dollars. We would appreciate your advocacy in helping us secure the resources we need to be able to keep individuals out of nursing homes.

642 North Broad Street Philadelphia, PA 19130-3409
Main Office: (215) 765-9000 • PCA Helpline: (215) 765-9040 • Fax: (215) 765-9066 • Website: www.pcaphl.org

Christine A. Arenson, M.D., Chairman • Rodney D. Williams, President

Thank you again for the opportunity to express our support of these proposed regulations. If you have any additional questions or would like to further discuss this opportunity to emphasize Pennsylvania's commitment to home and community based care, please do not hesitate to contact Becky Johnson, Long Term Care Access Director, at 215-765-9000, extension 2401, or by e-mail to bjohnson@pcaphl.org.

Sincerely,

RODNEY D. WILLIAMS
President

RDW/bj

Doc # 430235

Original: 2488

IRRC

From: Judi Hummel [jhummel@phca.org] on behalf of Alan Rosenbloom [arosenbloom@phca.org]
Sent: Thursday, September 01, 2005 11:17 AM
To: IRRC
Cc: pshea@klng.com; rpepe@klng.com
Subject: PHCA Comments on Proposed Rulemaking

08_29_05 DPW
)mments (PREADMI

Please see that attached letter from Alan G. Rosenbloom, President, Pennsylvania Health Care Association, regarding our comments on the proposed rulemaking concerning changes to clinical preadmission evaluations of nursing home applicants and to civil rights data collection and reporting requirements.

An original copy of the letter has been forwarded to Chairman McGinley's attention. Please call if you have any questions. Thank you.

<<08_29_05 DPW Comments (PREADMISSION)2.doc>>

Judi L. Hummel
Executive Assistant to Alan Rosenbloom
Pennsylvania Health Care Association
315 North Second Street
Harrisburg, PA 17101
(717) 221-7927
(717) 221-8690 Fax
jhummel@phca.org

Original: 2488

(Please note: Original letter was submitted on Pennsylvania Health Care Association letterhead.)

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.

* * * * * * * * *

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.

Original: 2488

IRRC

From: Wilmarth, Fiona E.
Sent: Monday, August 29, 2005 9:57 AM
To: IRRC
Cc: Sandusky, Richard M.; Stephens, Michael J.; Wyatte, Mary S.
Subject: FW: Comments on Proposed Reg #14-493 (IRRC #2488)

FYI – I received these comments via email this morning. They pertain to #2488.

-----Original Message-----
From: Stephanie Zweitzig [mailto:SZweitzig@pacounties.org]
Sent: Monday, August 29, 2005 9:44 AM
To: Wilmarth, Fiona E.
Subject: Comments on Proposed Reg #14-493 (IRRC #2488)

August 26, 2005

Fiona Wilmarth
Independent Regulatory Review Commission

Dear Ms. Wilmarth:

Attached please find the PA Association of County Affiliated Homes' comments regarding Proposed Regulation #14-493 (IRRC #2488), the Preadmission Requirements and Civil Rights Compliance for Nursing Facilities. If you have any questions, please feel free to call Mike Wilt at (717) 232-7554 ext. 3133.

Sincerely,
Stephanie Zweitzig
PACAH

Original: 2488

August 25, 2005

Department of Public Welfare
Office of Medical Assistance Programs
Attn: Regulations Coordinator
Room 515 Health & Welfare Building
Harrisburg, Pa. 17105

Re: Nursing Facility Services; Preadmission Requirements and Civil Rights Compliance for Nursing Facilities

Dear Sir/Madam:

The Pennsylvania Association of County Affiliated Homes (PACAH) appreciates the opportunity to comment on the above-reference proposed regulations. PACAH represents all 54 county and county affiliated nursing facilities in Pennsylvania, as well as non-county nursing facilities, and is an affiliate of the County Commissioners Association of Pennsylvania.

PACAH requests that the Department of Public Welfare (DPW) withdraw these proposed regulations. These regulations will impose further unnecessary and burdensome record keeping requirements on nursing facilities, require thousands more assessments to be conducted on applicants for nursing facilities by a system that cannot handle the current workload, and they would further promote an anti-nursing facility policy that has become all too familiar within DPW.

Once again, DPW is acting under the false assumption that nursing facilities do everything they can to admit residents that would be better served in other settings and resist placing residents back into the community. The issue is not, nor has it been, about the resistance of the facility; rather it is the lack of services and housing available in the community. This is frequently affirmed when the nursing facilities attempt to discharge residents to a community setting only to find services and housing dismally lacking. Of course, when given the option, most people would indicate they would rather live in a home or community based setting than a nursing home. The problem is, the option is not there in many circumstances. No amount of consumer education leading to informed decisions is relevant if the services are not available.

Local Area on Agency staff have difficulties now in performing the assessments in a timely manner. Even if additional staff is hired, the requirement to do thousands more assessments, (along with a confusing statement that there will be no fiscal impact), will

result in much longer delays in assessments being completed. The resultant ripple effect will have many individuals backed up in hospitals waiting for placement. They will be forced to remain in the most expensive care setting or be inappropriately discharged to home without appropriate and necessary services. Neither consumers nor referring facilities will be happy.

Since the vast majority of residents in county and county affiliated homes are Medicaid eligible on day one of admission or "spend down" shortly thereafter, the requirement for an assessment of all individuals likely to be Medicaid eligible within 12 months is not as big an issue with our facilities as with others in the long term care spectrum. However, the delays that would be caused in eligibility determination by adding many thousands more assessments into the system will be enormous. How will applicants be identified as "likely to be an MA conversion within 12 months..."? Add to this that residents and families are often reluctant to give such information until they are nearer to the time of needing MA coverage.

Regarding the requirements for gathering, keeping and reporting civil rights data for four years is a colossal waste of scarce resources for the nursing facilities. If DPW believes there are isolated instances of discrimination occurring at nursing facilities, they should by all means use their resources and investigate that facility. There are already regulations in place to address this issue and the existing regulations can be, and should be appropriately enforced when violated. But once again, to have the entire 700 plus nursing facilities compile meaningless statistics makes no sense. It is the same Department of Public Welfare that has enacted rate cuts for nursing facilities this year that is seeking more administrative requirements with fewer funds available.

The following are some other specific comments:

- Fiscal Impact – PACAH disagrees with the DPW opinion that they will experience savings in the MA – Long Term Care appropriation because individuals will choose HCBS as opposed to placements in nursing facilities. The reality is that as Community Choice expands more people have entered the Medicaid program in those counties on waiver programs, yet the occupancy rate for nursing facilities has remained approximately the same.
- Fiscal Impact – Relying on Intergovernmental Transfer funds (IGT) for the first year of funding the increased costs is a risky supposition. It is not known at what point in time these regulations, if ever, will become effective, and IGT funds may no longer be available.
- Fiscal Impact – There is no documentation for PACAH to be able to ascertain if the 11,000 increase in number of preadmission assessments is an accurate figure. There needs to be an explanation of the number of assessments for the first year and subsequent years.
- Definitions – 1187.2 – nursing facility application. The definition of what constitutes a request made orally is not clear, and does not provide specific guidelines to a facility staff.

- Definitions – Clinical Evaluation – If DPW is going to continue to refer to the Area Agencies on Aging as an independent assessor, then how is it that they are a provider of home and community based services?
- 1187.22 – Civil Rights Compliance – There are serious HIPAA considerations that have not been resolved in this section. Facilities do not collect that information at the present, and nursing homes within PACAH are HIPAA compliant. What is the format that will be used to collect the data? What is the interval to be specified by the Department? Requiring a facility to keep this information for four years without knowing what type of reporting format would be required by DPW is an unreasonable request.
- 1187.31 (2) (ii) (B) (IV) – Preadmission Requirements - Allowing a person to remain in a hospital setting for up to three additional days past what is necessary in order to get the assessment completed is an unacceptable waste of scarce dollars.

In summary, at a time when Medicaid resources are scarce, these proposed regulations will have the opposite effect than that sought by DPW. Requirements for additional assessments will strain a fragmented assessment process further, resulting in longer delays in approval, longer waits for individuals needing services, longer delays in providers receiving payments, and longer than necessary hospital stays. Requiring new civil rights data information when DPW has not presented any evidence of discrimination is also a waste of scarce administrative dollars and valuable staff time, to say nothing of intrusions upon the private concerns of nursing facility applicants.

PACAH urges DPW to withdraw these regulations at its earliest convenience. Please feel free to contact me if you have questions.

Sincerely,
Michael J. Wilt
Executive Director

14-443-5

Original: 2488

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

Pennsylvania Health Care Association
305 North Second Street • Harrisburg, PA 17101
(717) 221-1800 • FAX (717) 221-8687 • www.phca.org

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

cc: PAT FRAN JIM HE Original to AH. TK

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.

* * * * * * * * *

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.

14-493-5

Original: 2488

RECEIVED 2005 SEP -7 PM 2:1

Brady

creating the future of aging services for pennsylvania

panpha

an association of nonprofit senior services

CC: PAT FRAN JIM ... ON 40 A11C

RECEIVED 05 AUG 31 PM 2:01 BUR OF LTC PGMS REFER TO

August 29, 2005

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

Re: Nursing Facility Services; Preadmission Requirements and Civil Rights Compliance for Nursing Facilities [35 Pa.B. 4191]

Dear Regulations Coordinator:

As requested in the July 30, 2005 PA Bulletin, PANPHA provides the following comments On the Department's proposed rulemaking on preadmission and civil rights compliance for nursing facility services.

PANPHA is an association of Pennsylvania non-profit aging services providers, representing roughly 230 licensed nursing facilities in Pennsylvania. The vast majority of these facilities participate in the state/federal Medicaid program and will be impacted by the changes proposed by the Department. PANPHA members provide a wide array of care and services across the entire long-term care continuum, and have long embraced the concept of providing consumers with choice. One of our core areas of focus is ensuring consumer choice by offering the array of care and services necessary to provide consumers a broad range of choices within settings which are able to meet their care needs in a safe and cost efficient manner.

In light of its noble intent, it is our contention that this proposed amendment to 55 Pa. Code Ch. 1187 falls short in providing consumers with true "choice", ensuring that their care needs can be appropriately met in a community-based setting, or ensuring cost savings for Commonwealth taxpayers. PANPHA members have long held the concern that the Administration's efforts at "re-balancing" were focused more on forcing an anti "facility-based care" agenda than ensuring that consumers receive care in the safest, most cost efficient manner possible. It is our belief that these proposed regulatory changes verify that concern. Pennsylvania's demographic projections, the fiscal reality that in many cases, "facility-based care" is the less costly alternative for consumers with significant care needs, and the lack of an adequate community-based care infrastructure in some regions all demonstrate the need to give more thought to developing a delivery system with appropriate access and incentives rather than merely engaging in nursing home diversion as the "right answer". However, a response to a proposed regulatory change in

1100 Bent Creek Boulevard • Mechanicsburg, PA 17050 • 717.763.5724 • fax 717.763.1057 • www.panpha.org

the Pennsylvania Bulletin is not the appropriate venue to further make that case. Rather, we would like to provide the following comments on the proposed amendments to the regulation:

1. Ch. 1187.2 Definitions

Clinical Evaluation Definition

ISSUE: We find it concerning that this definition immediately sets the bar at whether " . . . the individual's needs may be met in a setting other than a nursing facility".

AMENDMENT: If the Department's intent is truly to create a consumer centered system of care and services, this should more appropriately read as follows:

CLINICAL EVALUATION: A COMPREHENSIVE ASSESSMENT BY THE DEPARTMENT OR ITS INDEPENDENT ASSESSOR OF AN INDIVIDUAL'S CARE AND SERVICE NEEDS, AND THE SETTING MOST CLINICALLY APPROPRIATE TO MEET THOSE NEEDS.

MA Applicant Definition

ISSUE: Clarification is needed on how the Department envisions determining whether a resident will be a "MA conversion resident" within 12 months from the date of admission.

Subchapter C. NURSING FACILITY PARTICIPATION

Sec. 1187.22 (18) (i) Civil Rights Data Reporting

ISSUE: We are unclear what purpose clinical data elements (F) and (I) serve in determining potential violations with relation to civil rights related discrimination in admission. They should be removed. We also have significant reservations about the use of occupancy rate as a determinant of a violation. Occupancy rate may not be an accurate indicator of available beds in many facilities, and does not speak to the clinical appropriateness of an admission. This should be removed, or at least clarified.

Sec. 1187.22 (18) (iii) Civil Rights Data Reporting

ISSUE: We object to the requirement that facilities also include all additional information requested of residents in their specific "civil rights report". If the Department feels that there may be other types of information that would be valuable in assessing compliance with the applicable statutes, those items should be specifically listed under Section 1187.22 (18)(i).

Subchapter D. DATA REQUIREMENTS FOR NURSING FACLITY APPLICATIONS AND RESIDENTS

Sec. 1187.31 (2) (iii) (B) Penalties

ISSUE: The Department seems to clearly provide its intent to determine the penalty within a range based on compliance history in the language of the subsection, yet stipulates that the " . . . civil money penalty may not be less than the nursing facility's total aggregate charges to the individual for services rendered during the period of noncompliance." This provision is unnecessarily punitive and may cause significant financial harm to certain facilities' financial positions and, by derivative, other residents of the facility.

AMENDMENT: The language beginning with " . . . but the civil money penalty may not be . . . during the period of noncompliance," should be removed.

Sec. 1187.31 (2) (iv) Maintaining Clinical Evaluation Reports

ISSUE: This requirement, when extended beyond current or former residents to "applicants," requires the facility to maintain records for an extended period of time on individuals for whom it was never responsible.
AMENDMENT: "Applicant" should be stricken from this section. If it is not stricken, "applicants" must be handled separately and the requirement should be record retention for one year following the date of application.

The additional administrative burden that the provisions of this proposed regulatory change require could not come at a worse time for nursing facility providers. The recently imposed 2.8% cap on MA reimbursement rate growth for FY 05-06 will result in a gap of almost $150 million in state/federal funds between what MA nursing facilities' cost reports show their funding needs to be, and the amount the Department is willing to pay. The number of facilities which lose significant amounts of money under the nursing facility assessment during FY 05-06 is also likely to increase significantly once the final figures are released. The requirements proposed in these regulatory changes represent yet another instance where the Administration is raising providers costs without any demonstrable increase in quality of resident care or allowance for increased provider efficiency. We urge the Department to withdraw these regulatory changes, and package them as part of a larger effort to create a sustainable, seamless delivery system which ensures consumers receive the care they need, in a setting which can safely provide it, in a manner that makes sense for consumers and taxpayers within the Commonwealth.

Sincerely,

W. Russell McDaid.
Vice President, Public Policy
russ@panpha.org

14-443-4

Original 2488

Genesis HealthCare℠

RECEIVED
2005 SEP -7 PM 2:11
REVIEW COMMISSION

cc: PAT FRED JIM ME Dr. QUALITY TOM

August 29, 2005

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

RECEIVED
05 AUG 31 PM 2:03
BUR OF LTC PGMS
REFER TO

Re: PA Bulletin, July 30, 2005: Proposed DPW Rule Changes Preadmissions/Civil Rights

On behalf of Genesis HealthCare Corporation, I write commenting on the proposed rules published in the Pennsylvania Bulletin on July 30, 2005 proposing to alter the pre-admission screening requirements for nursing facilities and imposing additional documentation of pre-admission inquiries.

Genesis HealthCare Corporation, headquartered in Kennett Square, is one of the state's largest long term care providers. We operate 46 facilities in the state; providing over a 1.5 million days of care to the most vulnerable residents of the state; about two-thirds of our care days are for Medicaid eligible individuals.

We strongly opposed the pre-admission screening requirements. We fully endorse the comments submitted by the Pennsylvania Health Care Association (PHCA). It appears as if the Commonwealth, once again, is listening to consultants that attempt to sell an aggressive opportunity without carefully researching the potential exposures to the state and our taxpayers.

1. We believe the state has far exceeded its legal authority. In the preamble the agency makes a vague reference to the Olmstead decision. Nothing in that decision gives the state the authority to impose requirements on private paying nursing home residents.

2. A casual reading of Part 2 of the State Medicaid Manual, suggests that the state may be jeopardizing its authority to secure Federal Medicaid funding of in its attempt to interfere with access to nursing home care for residents. First, it is suspect whether the state can impose a limit in such a manner as to impede access to nursing home services. The statute is clear; nursing home care is a mandated benefit. What is equally clear is that the rules impose time limits for FMAP (Federal Medical Assistance Percentage) funds. Federal matching for assessment performed on residents one-year prior to their applying would be highly questionable. Certainly, the state would require waiver authority to impose such a sanction. Be assured efforts would be made to oppose any such waiver request.

3. By setting a 12-month prior eligibility, the agency is putting itself at risk. First, for individuals required to be pre-screened, the state would not be permitted to change

eligibility criteria. Clearly the rules are the rules – what is good for the state, must also lock the state into specific criteria. Nursing homes cannot certify that potential Medicaid eligibility unless the rules are to stay the same for the duration of the pre-application process. Second, because the pre-screening process occurred, the state is making a commitment to expeditiously process the eligible individual's application, thus binding county agencies to accept the pre-screened application. There should be no excuse for the state not being able to process an application within 72 hours of submission as it would already have the information. Anticipate that consumers will be prepared to sue for specific performance. A quick review of other states that have attempted one-stop, fast track enrollment will document heightened advocacy for enrollment and added costs to county entities.

4. The current state efforts to create a streamlined, alternative placement option are fraught with delays and inadequate performance by the entities required to perform the functions. The state needs to get its act together on the current system before adding additional burdens onto care providers.

We urge the state to withdraw these proposed rules. Punishing the frail and vulnerable while promoting patronage rich bureaucracy is not the way to a market based solution for long term care issues.

Sincerely

Laurence F. Lane
Vice President
Government Relations

Original: 2488

14-493-6
cc: PAT
FRAN
BEN JIM
Me
Or 40 Alice
TV
Sue

COMMUNITY LEGAL SERVICES, INC.

Law Center North Central
3638 North Broad Street, Philadelphia, PA 19140
Phone: 215-227-2400
Web Address: www.clsphila.org

RECEIVED
05 AUG 31 PM 2:02
BUR OF LTC PGMS
REF TO

FAX TRANSMITTAL COVER SHEET

FAX NUMBER: 215-227-6486

DATE: 8-29-05

TOTAL NUMBER OF PAGES 5 **(INCLUDING THIS COVER SHEET)**

TO: Regulations Coordinator, Office of Medical Assistance Programs

ORGANIZATION: DPW

FAX NUMBER: (717) 787-4639

FROM: Pam Walz

DIRECT DIAL: (215) 227-2400 x 2431

CASE NAME:

FILE NO.:

MESSAGE: Comments on Proposed Rulemaking for Preadmission Requirements and Civil Rights Compliance

Please call the direct dial number above if there are any problems with this transmission. The information contained in this fax transmittal is legally privileged and confidential and intended only for the use of the individual or organization named above. If you receive this message but are not the intended recipient, please destroy the fax transmittal and notify the sender at the above direct dial number. Thank you for your cooperation.

TO BE COMPLETED AFTER FAX HAS BEEN TRANSMITTED:

DATE OF TRANSMISSION _____ **TIME:** _____

OPERATOR: _____

COMMUNITY
LEGAL SERVICES, INC.

Law Center North Central
3638 North Broad Street, Philadelphia, PA 19140
Phone: 215.227.2400, Fax: 215.227.2435
Web Address: www.clsphila.org

August 29, 2005

Regulations Coordinator
Office of Medical Assistance Programs
Department of Public Welfare
Room 515 Health and Welfare Building
Harrisburg, PA 17105
By Facsimile (717) 787-4639

Re: Proposed Rulemaking for Preadmission Requirements and Civil Rights Compliance

Dear Sir or Madam:

Thank you for the opportunity to comment on the proposed rulemaking, published in the Pennsylvania Bulletin on July 30, 2005, regarding preadmission requirements and civil rights data collection. We offer the following comments on behalf of our many disabled or frail clients who will benefit from Medical Assistance-funded long term care services, whether they are provided in a home, a community setting, or a nursing facility.

Civil Rights Data

We applaud the Department for taking a closer look at civil rights compliance. Collecting consistent data routinely is essential to assess whether a nursing facility has a pattern of restricting or denying admission based on factors that are illegal to consider. We recall one Community Legal Services client who was informed by nursing home staff that the client's family member could not be admitted because the nursing home had met its "Latino quota."

We offer some specific recommendations regarding the list of data at (18)(i) to be collected. First, we recommend that the Department specify how to categorize race and ethnicity. For consistency, the Department should thoughtfully determine and then inform nursing facilities of the exact categories they are to use in compiling racial and ethnic information. For example, will a dark-skinned person of Latin origin be captured in the data as "Hispanic," "Latino," "Black", or something else? The U.S. Census considers race and Hispanic origin to be distinct concepts that are captured separately. We understand that the categories are likely to be determined after the promulgation of the regulation, and we encourage the Department to look at the best available information and practices when determining the specific categories.

Second, we strongly recommend that the Department add "primary or preferred language" to the list of data to be collected. Discrimination against people because they do not

speak or understand English well is discrimination on the basis of national origin that is prohibited by Title VI of the Civil Rights Act of 1964. Nursing facilities that receive federal funds are subject to the U.S. Department of Health and Human Services' 2003 guidance regarding the prohibition of national origin discrimination and, accordingly, must take reasonable steps to provide people with limited English proficiency with meaningful access to their services. For your reference, the Department's Office of Income Maintenance has already developed a list of languages that is used to track the primary or preferred language of each County Assistance Office client.

Third, we ask that you delete "Social Security number" at 18(i)(G) from the list of data to be collected. We do not understand why a Social Security number would be relevant to monitoring civil rights compliance. The widespread request for and use of Social Security numbers has led to a sharp increase in identity theft with terrible financial and psychological consequences for victims. The Social Security Administration cautions against sharing a Social Security number with anyone who asks for it "even when you are provided with a benefit or service." SSA Publication No. 05-10064 (February 2004). We believe that collecting a nursing home applicant's Social Security number is unnecessary for the proposed regulation's stated purpose of deterring discrimination and rebutting unsubstantiated charges of discrimination.

We are also concerned about the statements at (18)(iii) and question the necessity of including them. These statements explicitly authorize nursing homes to ask anything about a nursing facility applicant as long as the question is not "otherwise prohibited by law." Nursing facilities could view this proposed regulatory language as an endorsement to ask all kinds of screening questions that may not be expressly prohibited by law but nonetheless violate the spirit of the law. For example, 42 C.F.R. 483.12(d) prohibits nursing facilities from requiring oral or written assurances that potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. Nursing facilities that want to avoid accepting Medicaid-eligible people ask about the value of an applicant's assets so they can make a determination that the person can pay for care at the higher private pay rate. While neither federal nor state law explicitly prohibits this type of screening, the Department should not promulgate regulations that, in a general and sweeping manner, appear to endorse such practices.

We are pleased that the Department has considered, in its definition of "nursing facility application", the variety of ways that requests for admission may be made. We believe that this definition should be tightened up still further. The Department should give thought to who may be considered a person with apparent authority regarding admissions. CLS had a client, discussed above, who called a nursing facility to inquire about admission for her Spanish-surnamed family member. She called the main facility number, which was answered by the receptionist. When she explained the purpose of her call, the receptionist responded that the facility had met its "Latino quota" and would not be accepting more Latinos at that time. Beyond the blatant illegality of the receptionist's response, our concern is that a receptionist may function as a sort of gate-keeper, dissuading callers from making a more formal application to a the facility's admissions director. To our client, the receptionist appeared to have authority to

tell her that there was no point in applying and perhaps even that she could not apply for her family member's admission. We have frequently heard from low-income clients, many of them members of racial or ethnic minority groups, that they were discouraged from applying to a nursing facility by the person who answered the phone and told them that the facility had no beds available or a long waiting list. It is crucial that these calls not be treated as a "casual inquiry or a request for information".

Finally, at (18)(iv), we recommend that the Department specify the frequency with which the data collected by nursing facilities will be submitted to the Department. Simply requiring the nursing facilities to collect the information is not enough of a deterrent to civil rights violations. The Department must have a systematic plan for receiving and reviewing the data in a routine and timely manner, and the proposed regulation should articulate a regular time frame for submission of the data. Specifying in the proposed regulation the intervals for submission of civil rights reports will also ensure that Department staff in the future maintain the responsibility that the current staff accept for monitoring civil rights compliance.

Preadmission screening

We support the Department's goal avoiding unnecessary institutionalization in nursing facilities by providing access for consumers and their caregivers to information about home and community based services (HCBS). Consumers generally prefer to remain in their homes rather than entering a nursing facility. Currently, if a consumer who has resources in excess of the Medical Assistance limit needs long term care, there is no mechanism to ensure that they receive information about the availability of HCBS prior to their entering a nursing facility. In addition, HCBS is a cost-effective use of Medical Assistance funds since it is less expensive than nursing facility care.

We have a few concerns about the implementation of the expanded pre-admission screening requirements. First, we have questions as to how this policy will operate in the not uncommon situation where a consumer needs long term care but the full extent of her assets is unknown. We have seen numerous cases in which an elderly person who had been admitted to a nursing home was unable, due to dementia or other incapacitating illness, to provide information about the location and extent of her assets. In this situation, it can take months for family members or other representatives to identify all of the person's resources. The custodians of investment accounts and other types of assets are prohibited from releasing any information without a power of attorney, which may or may not have been executed. Even where there is an agent under a power of attorney, delays in obtaining information can be substantial.

We are concerned whether family members of a hospitalized person in need of long term care (and under pressure from the hospital to be discharged before acute care insurance coverage ends) will be told that the placement process cannot be initiated until they can provide resource information which is unavailable to them. To address this, we suggest that the definition of "MA applicant" be clarified to provide that the determination whether an individual is considered

likely to be an MA conversion resident within 12 months should be based on the information which is reasonably available to the individual or person making a nursing facility application on behalf of the individual. The regulations should also provide that if income and/or resource information is not available, the applicant should be referred for a clinical assessment.

We also have a comment concerning the exceptions criteria at 31(2)(ii)(B). The first criteria is that the *nursing facility* have referred the applicant for a clinical evaluation prior to admission. However, it is our understanding that hospitals, not nursing facilities, generally request the clinical evaluations for hospitalized patients who appear likely to need long term care. Often this happens before a particular nursing facility has even been identified as a possible placement. It is also possible that a personal care home or, in fact, any individual may have requested the clinical evaluation. The regulation should be amended to make clear that the exception applies regardless of who referred the applicant for a clinical evaluation.

Again, thank you for the opportunity to offer comments and recommendations.

Sincerely,

Pam Walz
Director
Elderly Law Project

Beth Shapiro/pjs
Beth Shapiro
Staff Attorney
Elderly Law Project

cc: Independent Regulatory Review Commission
Honorable Jake Corman
Honorable Vincent J. Hughes
Honorable George Kenney, Jr.
Honorable Frank Oliver

Original: 2488

14-493-13 cc: PAI FRAN Me ORIGINAL Hegw

beverly healthcare

August 29, 2005

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
Beverly Enterprises Inc. strongly opposes the proposed changes to clinical preadmission requirements.

Serious Concerns With Proposed Preadmission Requirements

Presently, individuals seeking admission to our nursing facilities may be admitted pending completion of the OPTIONS evaluation by the Area Agency on Aging. While every effort is made to complete the OPTIONS assessment before admission, admission is not delayed or deferred pending completion when the patient seeks nursing facility placement and when nursing facility placement is urgent.

There are many times when the patient needs to be transferred from the hospital to the nursing home in the most expeditious manor possible. This regulation will dramatically slow the process and will ultimately be detrimental to the patient, and more costly to the Commonwealth as the hospital length of stay increases. Additionally, we do not think it is appropriate, nor perhaps legal, to question or investigate whether patients will become financially eligible for Medicaid at some future date.

Our primary concern is for the well being of the patient. A regulation that will unnecessarily increase hospital stays is poor treatment of those we serve and irrational in its logic. Please consider amending the proposed regulation so as not to burden our patients with an unnecessary, unwieldy, time consuming procedure that will adversely affect patient care.

Respectfully yours,

William J. Meenan
Regional Vice President

Region 3 Office

300 Penn Center Boulevard, Suite 500
Pittsburgh, PA 15235
412.824.3397 • fax: 412.824.4918
www.beverlycares.com

Original: 2488

August 27 2005

14-483-7

To - Dept. of Public Welfare
Regulations Coordinator

From - Ellen F. Millick

Ref - PA Bulletin Doc # 05-1435 Budget

I am writing to strongly object to Act 42 and Act 43 in the Commonwealths budget. These acts will severly limit needed health care to older citizens. The impact on the Baby Boomer generation will be devestating

My husband fell and broke his hip. If he had been denyed rehabilitation from Medicare in a nursing home, the end of his life would have been much more painful and stressful for all of the family. I could not have cared for him at home and he would not have received the daily re-hab that he got for two months in the nursing home. Pennsylvania is already high in available home and community based care. To deny citizens the care to which they are entitled through Medicare is outrageous

I hope this legislation will be carefully reconsidered before final action is taken. Our senior citizens deserve better. We vote, too, you know.

A very concerned senior citizen,

Ellen F. Millick
411 Dutton Mill Rd.
Malvern, PA 19355

Original: 2488

14-493-2 cc: Pat Phil Jim Me Or Go Alice TV &

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

RECEIVED
05 AUG 31 PM 2:02
BUR OF LTC PGMS
REFER TO

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

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.

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

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

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.

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.

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 48th 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.

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, 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

#14-493-1

Original; 2488

PACAH
PENNSYLVANIA ASSOCIATION OF COUNTY AFFILIATED HOMES
17 NORTH FRONT STREET • HARRISBURG, PA 17101-1624 • (717) 232-7554 • FAX (717) 232-2162

2005 AUG 31 11:04

August 25, 2005

Department of Public Welfare
Office of Medical Assistance Programs
Attn: Regulations Coordinator
Room 515 Health & Welfare Building
Harrisburg, Pa. 17105

Re: Nursing Facility Services; Preadmission Requirements and Civil Rights Compliance for Nursing Facilities

Dear Sir/Madam:

The Pennsylvania Association of County Affiliated Homes (PACAH) appreciates the opportunity to comment on the above-reference proposed regulations. PACAH represents all 54 county and county affiliated nursing facilities in Pennsylvania, as well as non-county nursing facilities, and is an affiliate of the County Commissioners Association of Pennsylvania.

PACAH requests that the Department of Public Welfare (DPW) withdraw these proposed regulations. These regulations will impose further unnecessary and burdensome record keeping requirements on nursing facilities, require thousands more assessments to be conducted on applicants for nursing facilities by a system that cannot handle the current workload, and they would further promote an anti-nursing facility policy that has become all too familiar within DPW.

Once again, DPW is acting under the false assumption that nursing facilities do everything they can to admit residents that would be better served in other settings and resist placing residents back into the community. The issue is not, nor has it been, about the resistance of the facility; rather it is the lack of services and housing available in the community. This is frequently affirmed when the nursing facilities attempt to discharge residents to a community setting only to find services and housing dismally lacking. Of course, when given the option, most people would indicate they would rather live in a home or community based setting than a nursing home. The problem is, the option is not there in many circumstances. No amount of consumer education leading to informed decisions is relevant if the services are not available.

Local Area on Agency staff have difficulties now in performing the assessments in a timely manner. Even if additional staff is hired, the requirement to do thousands more assessments, (along with a confusing statement that there will be no fiscal impact), will

result in much longer delays in assessments being completed. The resultant ripple effect will have many individuals backed up in hospitals waiting for placement. They will be forced to remain in the most expensive care setting or be inappropriately discharged to home without appropriate and necessary services. Neither consumers nor referring facilities will be happy.

Since the vast majority of residents in county and county affiliated homes are Medicaid eligible on day one of admission or "spend down" shortly thereafter, the requirement for an assessment of all individuals likely to be Medicaid eligible within 12 months is not as big an issue with our facilities as with others in the long term care spectrum. However, the delays that would be caused in eligibility determination by adding many thousands more assessments into the system will be enormous. How will applicants be identified as "likely to be an MA conversion within 12 months..."? Add to this that residents and families are often reluctant to give such information until they are nearer to the time of needing MA coverage.

Regarding the requirements for gathering, keeping and reporting civil rights data for four years is a colossal waste of scarce resources for the nursing facilities. If DPW believes there are isolated instances of discrimination occurring at nursing facilities, they should by all means use their resources and investigate that facility. There are already regulations in place to address this issue and the existing regulations can be, and should be appropriately enforced when violated. But once again, to have the entire 700 plus nursing facilities compile meaningless statistics makes no sense. It is the same Department of Public Welfare that has enacted rate cuts for nursing facilities this year that is seeking more administrative requirements with fewer funds available.

The following are some other specific comments:

- Fiscal Impact – PACAH disagrees with the DPW opinion that they will experience savings in the MA – Long Term Care appropriation because individuals will choose HCBS as opposed to placements in nursing facilities. The reality is that as Community Choice expands more people have entered the Medicaid program in those counties on waiver programs, yet the occupancy rate for nursing facilities has remained approximately the same.
- Fiscal Impact – Relying on Intergovernmental Transfer funds (IGT) for the first year of funding the increased costs is a risky supposition. It is not known at what point in time these regulations, if ever, will become effective, and IGT funds may no longer be available.
- Fiscal Impact – There is no documentation for PACAH to be able to ascertain if the 11,000 increase in number of preadmission assessments is an accurate figure. There needs to be an explanation of the number of assessments for the first year and subsequent years.
- Definitions – 1187.2 – nursing facility application. The definition of what constitutes a request made orally is not clear, and does not provide specific guidelines to a facility staff.

- Definitions – Clinical Evaluation – If DPW is going to continue to refer to the Area Agencies on Aging as an independent assessor, then how is it that they are a provider of home and community based services?
- 1187.22 – Civil Rights Compliance – There are serious HIPAA considerations that have not been resolved in this section. Facilities do not collect that information at the present, and nursing homes within PACAH are HIPAA compliant. What is the format that will be used to collect the data? What is the interval to be specified by the Department? Requiring a facility to keep this information for four years without knowing what type of reporting format would be required by DPW is an unreasonable request.
- 1187.31 (2) (ii) (B) (IV) – Preadmission Requirements - Allowing a person to remain in a hospital setting for up to three additional days past what is necessary in order to get the assessment completed is an unacceptable waste of scarce dollars.

In summary, at a time when Medicaid resources are scarce, these proposed regulations will have the opposite effect than that sought by DPW. Requirements for additional assessments will strain a fragmented assessment process further, resulting in longer delays in approval, longer waits for individuals needing services, longer delays in providers receiving payments, and longer than necessary hospital stays. Requiring new civil rights data information when DPW has not presented any evidence of discrimination is also a waste of scarce administrative dollars and valuable staff time, to say nothing of intrusions upon the private concerns of nursing facility applicants.

PACAH urges DPW to withdraw these regulations at its earliest convenience. Please feel free to contact me if you have questions.

Sincerely,

Michael J. Wilt
Executive Director

Brady

14-493-9

Aug. 23, 2005

Gentlemen,

The Daily Local article in yesterday's paper, as written by Janet Calloton disturbs me.

The same day we had a speaker in our Senior's only apartment building.

The proposals she outlined and he explained for our futures are not truly good for us. We are being pushed back & other proposals planned.

It was explained that there are so many of us.

Too many of us have stroken & no longer comprehend com-

plicated programs.

The newspapers & TV announcers take time to detail retirement plans for others.

Make the right decision,

Truly,

V. Wayne Regester

Mr. Jack M. Regester
596 Dickinson Ct. # 411
Exton, PA 19341

Original; 2488

14-493-11 CC: Pat Flaud Gina Lee Original to Alice

PENNSYLVANIA HEALTH LAW PROJECT

650 SMITHFIELD ST., SUITE 2130
PITTSBURGH, PA 15222
TELEPHONE: (412) 434 - 5779
FAX: (412) 434 - 0128

LAFAYETTE BUILDING, SUITE 900
437 CHESTNUT ST.
PHILADELPHIA, PA 19106
TELEPHONE: (215) 625-3663
FAX: (215) 625-3879
HELP LINE: 1-800-274-3258
TTY: 1-866-236-6310
WWW.PHLP.ORG

1414 N. CAMERON ST., SUITE B
HARRISBURG, PA 17103
TELEPHONE: (717) 236-6310
FAX: (717) 236-6311

RECEIVED
05 SEP -7 AM 11:03
BUR OF LTC PGMS
REFER TO

August 23, 2005

SEP 08 2005

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

Re: Pa.B.Doc. #05-1435 Nursing Facility Services: Preadmission Requirements and Civil Rights Compliance for Nursing Facilities

Dear Regulations Coordinator:

I am writing on behalf of the Consumer Subcommittee of the Medical Assistance Advisory Committee, the official advisory body to the state's Medical Assistance program, to express the strongest support for the above-referenced proposed regulation, which was published on July 30, 2005. The regulation addresses two major issues of longstanding concern to the subcommittee: 1) the equitable distribution of nursing facility services, and 2) the need to inform applicants to nursing facilities about home and community-based service alternatives.

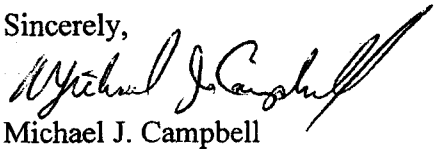
The first issue has been a concern of the Subcommittee for two decades. In the mid-1980s, the Subcommittee first urged DPW to investigate and address the fact that Pennsylvania's nursing home system was highly segregated. This high degree of segregation was documented by researchers. See e.g. Smith, D.B. 1993. The Racial Integration of Health Facilities. Journal of Health Politics, Policy and Law. 1993 Winter, 18:851. However, instead of banning discrimination against applicants to nursing facilities, or requiring a first-come first-served admissions policy as other states had done, Pennsylvania turned its back on the issue and was content to limit the scope of its annual civil rights compliance surveys to whether the white residents of nursing facilities located in African-American neighborhoods were segregated by room or at the dining table. Our neighboring states went farther. New York required all nursing homes to establish written admission policies to ensure compliance with state and federal anti-discrimination laws, as well as maintain a log of all persons referred for admission. 10 N.Y. A.D.C. 415.26 (i)(1)(ix)(x) and (xi). New Jersey required nursing homes to establish a single waiting list in chronological order. N.J. Admin. Code 8:39-5.2(a). Other states established first-come, first-served nursing home admissions policies. The modest step embodied by these proposed regulations, i.e. requiring facilities to keep a written record of applications for four

years, which will be available for review in order to assure that illegal discrimination is not occurring, is long overdue. Absent this tool, civil rights monitoring is virtually impossible.

The Subcommittee's second concern, that of informing applicants to nursing homes of their alternatives before they have discarded their lifelong residence and made the psychological as well as physical leap to institutionalization, is well described by the Department in the background section to the proposed regulation. In addition to the cited benefits of the proposed policy change, the requirement of a preadmission screening and the dissemination of information about alternatives would help protect those consumers who have paid privately since being admitted to a nursing facility, only to learn when the money has run out that they did not qualify for Medical Assistance payment because they did not need the nursing home level of care. Such cases are extremely painful, as they render frail elderly Pennsylvanians homeless.

Should the need arise, the Subcommittee would be happy to present testimony before the Regulatory Review Commission in support of these regulations.

Sincerely,



Michael J. Campbell
Pennsylvania Health Law Project
For the Consumer Subcommittee
Medical Assistance Advisory Committee

cc: Consumer Subcommittee

Original: 2488

Mary 400 N. Walnut St.
West Chester, Pa. 19380-2432

August 23, 2005

14-493-8

Dept. of Public Welfare
Office of Medical Assistance Programs
Room 515 - Health Welfare Bldg.
Harrisburg, Pa. 17105

Attention Regulations Coordinator,

I read with concern THE TOUGH CHANGES in Penna's new State Health Care, as I am a resident in a small Assisted Living facility. Already our 70 residents, whose average age is 87 years, are anxious over the new Assisted Living Regulations, and how our monthly bills may reflect the added costs in meeting the new regulations here.

As I understand Act 43 (which had not been considered since the 1930's), a child of "an indigent person" can be held responsible for the parents' cost of care. This seems very unwise to me; two of my four grandchildren are in College, and their parents work full time. That would place a real and unfair burden on them.

PLEASE RECONSIDER and CHANGE or REPEAL THE LAW - Act 42 and Act 43 as passed in July as part of the Budget Penna. Bulletin Doc. # 05-1435

I am truly disappointed to read that Pennsylvania ranks so low — possibly 48th) is available home and community-based care.

Sincerely,
Rebecca F. McIlvaine

Original: 2488

IRRC

From: Diane DeMarra [DDEMARRA@haponline.org]
Sent: Friday, October 07, 2005 2:22 PM
To: IRRC
Subject: HAP's Comments on Preadmission Requirements

2005 OCT -7 PM 2:39

Preadmission req. prop rule.do...

Mr. McGinley:

Please see the attached comments on the proposed rulemaking regarding the preadmission requirements and civil rights compliance for nursing facilities. While we understand we are submitting these comments beyond the established comment period deadline, we are hopeful you will take our comments into consideration. If you have any questions related to our comments, please contact Melissa Dehoff, director, health care continuum finance policy, at (717) 561-5318, or via email at mdehoff@haponline.org.

Thank you.

Diane DeMarra, Secretary
Integrated Delivery Systems
(717) 564-9200
ddemarra@haponline.org

HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

October 7, 2005

John R. McGinley
Chairman
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Mr. McGinley:

The Hospital & Healthsystem Association of Pennsylvania (HAP), on behalf of its members, which include more than 225 acute and specialty hospitals and health systems, of which nearly half offer nursing facility services, appreciates the opportunity to comment on the proposed rulemaking regarding preadmission requirements and civil rights compliance for nursing facilities. While HAP supports the underlying intent of this proposed rulemaking to ensure individuals receive the best care in the most appropriate location by being assessed prior to admission, we have significant concerns with the rule as proposed. Our concerns focus on the qualifications of the assessors and the timeliness of the assessments.

Qualifications of Assessors: The proposed rulemaking indicates the assessors would be comprised of individuals from local area agencies on aging (AAA). What are the qualifications of these individuals? Will they have the necessary training, education, and clinical knowledge to make an accurate assessment of need for skilled care?

Recommendation: Both the ability of AAAs to absorb this extra responsibility as well as the adequacy of the training and education of their staff to conduct accurate assessments should be evaluated prior to implementation. HAP feels the assessors assigned to this significant task should have the education, clinical background and training to complete an appropriate assessment of skilled needs. To ensure assessments are completed accurately and in the best interest of the patients, HAP feels these individuals should be nurses or individuals who have some form of medical training.

Timeliness of Assessments: In addition, HAP has concerns that the assessments may not be completed on a timely basis, delaying discharge and increasing costs for insurers, Medicare, and Medicaid. For example, the proposed rulemaking indicates assessors have a timeframe of three days to assess individuals that are in a hospital. The three-day timeframe adds additional days, which could lead to unnecessary costs to the hospitals as they wait for the results of the assessment. According to members of HAP's Council for Long-Term Care, there currently exists great variability in the timeliness of assessments for home and community based services based on region, and some regions are reporting waits of more than a month for completion of these assessments. If AAAs are unable to handle their current caseload, how will they efficiently and effectively absorb this added

responsibility? Pennsylvania hospitals already experience significant challenges in finding timely and appropriate placements for patients ready for discharge. Delays in proper placement of patients ready for discharge can lead to other problems, such as emergency department diversion, because other beds are not available. This proposed rulemaking creates yet another obstacle, and could create barriers for patients needing access to hospital care because beds are not available.

Recommendation: Completion of the assessment should not be a prerequisite for admission to a nursing facility.

Medicaid Conversion Requirements: HAP questions the requirement of assessments being conducted on nursing facility applicants who "expect" to use Medicaid as a payment source within 12 months of admission. Not only is this requirement administratively burdensome for nursing facilities, but also inappropriate. The requirement should be restricted to those individuals who are Medicaid applicants and not extended to those that are "likely" to convert to Medicaid.

Recommendation: The requirement should be restricted to those individuals who are Medicaid applicants and not extended to those that are "likely" to convert to Medicaid.

Civil Rights Data Collection: While HAP understands the need to ensure discrimination is not occurring within the continuum of care in which patients are being cared for, we have significant concern with the impact this administrative task will have on already overburdened nursing facility staff. This requirement is burdensome and would take staff away from their primary role, which is that of patient care. Nursing facilities are continually being forced to comply with additional data collection requirements with no additional reimbursement. In the end, it is patient care that is ultimately negatively impacted by unfunded mandates. Additionally, the Department of Public Welfare has not provided any validation of a problem that necessitates the need for these additional collection requirements.

Recommendation: The requirement should be eliminated due to the additional and unfunded administrative burden, particularly in the absence of validation justification.

Hospitals and hospital-based nursing facilities experience many challenges in delivering the high quality of care the citizens of Pennsylvania deserve and have come to expect. We all have an obligation to ensure that new regulations provide benefits to patients and do not merely add additional costs and administrative burden. We do not believe this proposed rulemaking meets that test.

HAP is committed to ensuring access to quality care—the right care, in the right place, delivered by the right people. We are not convinced that these regulations would contribute to that goal.

We appreciate the opportunity to provide our comments. Questions on these comments may be directed to Melissa Dehoff, HAP's director, health care continuum finance policy, at mdehoff@haponline.org, or (717) 561-5318.

Sincerely,

Paula A. Bussard

PAULA A. BUSSARD
Senior Vice President
Policy & Regulatory Services

PAB/dd

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF GENERAL COUNSEL

Original: 2488

DATE: October 5, 2005

SUBJECT: **Public Comment**
Nursing Facility Services; Preadmission Requirements and Civil Rights Compliance for Nursing Facilities- # 14-493
Proposed Regulation

TO: Kim Kaufman
Executive Director
Independent Regulatory Review Commission

FROM: Ruth D. O'Brien RDO 10/3/05
Senior Assistant Counsel

Attached is a public comment (15) received regarding the above proposed regulation.

Attachments

cc: Scott Johnson
Norris Benns
Melanie Brown
Sandra Bennett

PENNSYLVANIA PROTECTION & ADVOCACY, INC.

1414 N. Cameron Street, Suite C
Harrisburg, PA 17103

Phone:
Voice: 800-692-7443 or 717-236-8110
TTY: 877-375-7139 or 717-346-0293

Fax:
717-236-0192

Email:
ppa@ppainc.org

September 27, 2005

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

Pennsylvania Protection & Advocacy (PP&A) is the designated advocacy organization on behalf of persons with disabilities authorized under federal law. I write to express PP&A's full support for the proposed rulemaking entitled Nursing Facility Services; Preadmission Requirements and Civil Rights Compliance for Nursing Facilities .

Based on my own years of experience and the thousands of calls that PP&A receives each year, I can state with certainty that people with disabilities prefer to live in their own homes and to be integrated in their own communities. Giving persons with disabilities more information earlier in the process will help them make the informed choices necessary to achieve these goals. Time and time again, PP&A staff has witnessed the difficulty of people returning to the community once they have lost their houses or apartments. Indeed, it is not uncommon for persons with disabilities to lose their housing during a relatively short stay in a facility. Finding a new place to live then becomes the primary obstacle for persons to return to their communities. Thus, it is of the utmost importance that information on community alternatives be given before the person enters a facility and runs the risk of losing their housing.

PP&A also supports the provision requiring the collection of data on civil rights compliance. PP&A has on numerous occasions heard from persons with disabilities or their family members describing examples of discrimination by nursing homes in their selection process.

Finally, representatives of the nursing home industry have suggested that these regulations violate the Supreme Court's *Olmstead* decision. Nothing could be further from the truth. I was co-counsel in the Third Circuit case of *Helen L. v. Didario*, which preceded the *Olmstead* decision and was the first case to apply the interpretation of the ADA later adopted by the Supreme Court. The *Olmstead* case is about the rights of unnecessarily segregated persons with disabilities to leave congregate facilities. The decision has nothing to do with the issue of persons seeking to enter such facilities and, to my knowledge, every court to consider the issue has rejected the type of argument being made by the representatives of the nursing home industry.

It is critically important that these regulations be adopted as proposed.

Sincerely,

Ilene W. Shane
CEO

14-493-15

Bruckys

FAX Cover Sheet

PENNSYLVANIA PROTECTION & ADVOCACY, INC.
1414 N. Cameron Street, Suite C, Harrisburg, PA 17103
800/692-7443...717/236-8110...717/236-0192 (fax)

TO: Regulations Coordinator, DPW office of Medical Assistance

FROM: Ilene Shane, CEO

FAX #: 787-4639

SUBJECT: Nursing Facility Services

DATE: 9/27/05

PAGES (including this cover sheet): 2

COMMENTS:

cc: PAT FRAN Me Original to Alice JL

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

DATE: 10/4/2005

TO: Ruth O'Brien
Office of General Counsel
OGC Regulatory Unit

FROM: Gail Weidman
Bureau of Long-Term Care Programs
Program Analysis Review Section

REGULATION #: 14-493

Our Bureau has received the attached public comments regarding the above proposed regulation.

Comment Letter #: 15

Gail Weidman

cc: Gail Weidman
Policy Unit

2005 OCT -5 PM 3:33

14-493-10

Original: 2488

RECEIVED SEP 7 2005 PROGRAM ANALYSIS AND REVIEW SECTION

Wellington at HERSHEY'S MILL

REFER TO: Brady

cc: PAT FRAN

RECEIVED 05 SEP -6 PM 12:48 BUR OF LTC PGMS REFER TO

SEP 07 2005

Dept. 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 for Nursing Facilities
Chapter 1187

As part of the ownership and management of a 60 bed skilled nursing facility, we are concerned about the proposed change to expand requirements regarding admissions. As advocates for seniors, we feel this would be extremely detrimental.

We have questions:

1. In what time frame would this be accomplished? Are there any time constraints? Could it be done prior to discharge from a hospital? A delay could result in death while waiting for needed services. An ill person is in need of immediate assistance to meet their medical needs and is at risk. While waiting for an evaluation, who will take care of an elderly person that is sent home alone, who can't walk or care for themselves?
2. With a shortage of health care workers, where will reliable, trustworthy employees come from to provide home care services?
3. Would there be an adequate number of evaluations to meet the requests in a timely manner?
4. Is there adequate funding to provide these services? Would home services be covered and for how long?
5. If there is an eligibility requirement, how many of the total in need would be provided for?

There must be a better way to notify people of the opportunity for in-home care services without denying them immediate services and delaying care.

We hope serious consideration will be given to the flaws in this recommendation that applicants must be evaluated before admission to a skilled nursing facility. An applicant can always leave a skilled nursing facility if they choose to do so.

Sincerely,

Robert M. Peterson
President of Operations

Sara Burdan
VP of Marketing & Operations

1361 Boot Road • East Goshen • West Chester, Pennsylvania 19380 / 484-653-1200 • Fax 484-653-1201

Original: 2488

14-493-14

Pennsylvania Association of Area Agencies on Aging, Inc.
525 South 29th Street, Harrisburg, Pennsylvania 17104
Phone: (717) 541-4214 • Fax: (717) 541-4217

RECEIVED
SEP 19 2005
PROGRAM ANALYSIS AND REVIEW SECTION

RECEIVED
05 SEP 15 PM 2:06
BUR OF LTC PGMS
REFER TO

September 7, 2005

Department of Public Welfare
Office of Medical Assistance Programs
Room 5151 Health and Welfare Building
Harrisburg, PA 17105

Attn: Regulations Coordinator

The Pennsylvania Association of Area Agencies on Aging (P4A) would like to acknowledge our full support of the proposed rulemaking entitled **Nursing Facility Services; Preadmission Requirements and Civil Rights Compliance for Nursing Facilities**. The changes outlined will provide information and service options to people that might otherwise not realize the availability of home and community-based support. In addition, capturing information regarding nursing home applicants as it relates to civil rights data can only serve to strengthen the Commonwealth's assurance of equal treatment of every seniors requesting nursing home support.

For more than thirty years, Pennsylvania's Aging Network has served as a focal point of services to our aging population. Fifty-two (52) Area Agencies on Aging serve the Commonwealth's sixty-seven (67) counties. County and non-profit Area Agencies on Aging (AAA's) are responsible for information, planning, developing, monitoring, providing cost-effective care, services, and advocacy to Pennsylvania's older population. AAA's are community designers and builders of support systems that enable older people to be active and vital in their community. AAA's also serve as gatekeepers, providing assessment and options, as alternatives to costly institutionalization. We strongly recommend assessments continue to be provided through the network of AAA's.

Touching lives every day, AAA's bring 2,897 employees with more than 20,000 years of cumulative experience together to serve as advocate and deliverer of in-home and community supportive care. Program emphasis has been increased to address the growing number of older frail and homebound individuals. However, AAA's have not lost sight of a desire to build continuums of care into the long-term care system. It is important to note that through AAA initiatives, nearly 76,000 volunteers provide over 2.4 million hours of community service. Statistical evidence demonstrates that approximately 490,000 individuals reach out each year to AAA's information and referral systems (I&R) for assistance and advice and more than 300,000 receive community based services.

The member agencies of P4A know that people that are given home and community-based service options earlier in the decision making process would choose to receive

services outside of nursing homes. While we acknowledge the need for nursing home services as part of a continuum of care, the long-term care system needs to be rebalanced to ensure that people can choose the least restrictive model of care available. As the population of seniors continues to increase, community-base care must be presented on a level playing field with the option of nursing home care. By introducing the pre-admission assessment earlier in the process, 12 months prior to financial eligibility, the number of people, both people over and under the age of 60, will have the information necessary to make an informed decision about their future.

The P4A also supports the proposed rule on record retention in order to ensure civil rights compliance by nursing homes.

We appreciate this opportunity to submit comments. Do not hesitate to contact us at 717-541-4214 with any questions regarding this submission.

Sincerely,

M. Crystal Lowe
Executive Director
Pennsylvania Association of Area Agencies on Aging

Cc: Nora Dowd Eisenhower, Secretary
PA Department of Aging

Board Members
Pennsylvania Association of Area Agencies on Aging

Brian Baxter
Wojdak Consulting