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VIA USPS (FIRST CLASS) & E-MAIL (JENBURNETT@STATE.PA.US)
Jennifer Burnett, Deputy Secretary
Department of Aging
Department of Public Welfare
Office of Long-Term Living
555 Walnut Street, Fifth Floor
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RE: ASSISTED LIVING WAIVER PRIORITIES

Dear Deputy Secretary Burnett,

On behalf of the Consumer Subcommittee of the Medical Assistance Advisory Committee, we urge the Office of Long-Term Living (OLTL) to address several issues as it finalizes an assisted living waiver application to the Centers for Medicare and Medicaid Services (CMS). The Subcommittee's recommendations below address (1) quality of care and safety for waiver recipients, and (2) policies that promote deinstitutionalization by reducing the potential for discrimination against Medicaid recipients.

The Nursing Home Reform Law already protects Medicaid enrollees in nursing homes from being treated differently from private-pay residents. We believe many of the same concepts, if applied to Medicaid waiver certified assisted living facilities, will serve to protect the interests of consumers while preventing premature institutionalization in nursing homes. We appreciate your conversations with the Subcommittee and others through the Assisted Living Waiver Workgroup and suggest the following priorities:

Waiver Priority #1: Room Holds for Hospitalized Residents

The right to hold a room, or at least return to a room in a facility, can be vitally important to an assisted living resident. A short hospitalization should not force an assisted living resident to move permanently from the facility.

Pennsylvania should guarantee a Medicaid Waiver resident's right to return to her unit in an assisted living facility following a hospitalization. Our understanding is that the Commonwealth will make no payment for services while a resident receiving the Assisted Living Waiver is hospitalized. Non-payment for services should not endanger this resident's right to return to her room. When the resident has paid the room and board for the month in question, Pennsylvania should require the facility to permit the resident to return after the hospitalization, even when there has been no payment for services.

Waiver Priority #2: Prevent Discrimination against Waiver-Eligible Assisted Living Residents

Accepting Medicaid Coverage from Waiver-Eligible Residents: Medicaid waiver certified assisted living facilities should be required to accept Medicaid as payment in full from individuals eligible to receive the Assisted Living Waiver. This is a basic Medicaid principle that applies to nursing facilities and other Medicaid-certified providers. Medicaid eligibility exists to provide necessary health care to low-income persons who otherwise could not afford it. This protection is weakened if a Medicaid waiver certified provider is allowed to refuse Medicaid coverage.

No Private Pay Duration of Stay Requirements: Medicaid waiver certified assisted living facilities should be required to accept Medicaid coverage for waiver-eligible residents without requiring private payment for a certain number of months as a prerequisite for accepting Medicaid. This was a significant problem in New Jersey, where the practice of requiring residents to pay privately, prior to acceptance of Medicaid, was identified by the National Senior Citizens Law Center, which analyzed ALR disclosure statements. In most of these cases, the required duration of private payment was ten months or more.

Any private-pay prerequisite – but particularly one of ten months or more – could make Medicaid coverage illusory for many beneficiaries in need of assisted living services. We agree with the OLTL's position, articulated during the June 29, 2010 meeting with stakeholders, that a private pay duration of stay requirement would be a violation of the assisted living residences' (ALRs') contract with the Commonwealth. Rather than requiring residents to pay privately for a period of time before using Medicaid reimbursement, Medicaid Waiver Certified providers must be required to accept Medicaid reimbursement from the outset

Access to Medicaid Payment after a Facility Withdraws from the Medicaid Program: If a Pennsylvania nursing home is Medicaid certified when a particular resident is admitted, Medicaid reimbursement in that facility continues to be an option for that resident, whenever she meets the financial and other criteria to qualify for Medicaid coverage. Under federal law, a nursing home that has decertified from Medicaid must accept Medicaid coverage for any Medicaid-eligible resident who was living in the nursing home at the time of decertification, even if the resident did not become Medicaid eligible until after the decertification.[1]

[1] See 42 U.S.C. §1396r(c)(2)(F)(i).

The same rule should be applied to residents of Medicaid waiver certified assisted living facilities. Otherwise, long-term care consumers will have an incentive to seek care in a Medicaid-certified nursing home, where Medicaid payment on the resident's behalf will be guaranteed. Unless appropriate protections are in place, Medicaid waiver certified assisted living facilities could voluntarily decertify themselves, and then refuse to accept Medicaid coverage for their current residents.

Oregon protects already-admitted residents of Medicaid Waiver Certified assisted living facilities through the use of gradual withdrawal contracts. Under this model the facility is not required to accept Medicaid payment on behalf of residents who move into the facility after the effective date of the contract. However, the facility must accept Medicaid payment for residents who had previously paid privately, then became waiver eligible, but who resided in the facility prior to the effective date of the contract. The facility continues to receive and accept Medicaid payment for residents who are on Medicaid at the time the gradual withdrawal contract goes into effect.

Waiver Priority #3: Freedom of Provider Choice

Assisted living waiver recipients should be free to choose their supplemental health care providers notwithstanding the assisted living facility's policy on providing supplemental health care. In accordance with 42 CFR § 431.51, a waiver participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of Section 1915(b) or another provision of the Social Security Act.

Since the statute and regulations merely permit, but do not require, assisted living providers to designate certain supplemental health care providers for their residents, the waiver should include a freedom of choice provision as a stipulation for participating in the ALR waiver. Any concerns of assisted living residences regarding the use of supplemental health care providers that are not designated by the facility are already addressed by the regulations.

Our concern for residents' choice of providers was voiced months ago by advocates during the drafting of final regulations for the licensure of assisted living residences. The Department of Public Welfare (DPW) addressed the concern in the Comment/Response document provided to the Independent Regulatory Review Committee. In that document, DPW noted that, while the regulations cannot conflict with Act 56, "waiver programs are outside the scope of these regulations."[2] We urge the Department to address this matter in its waiver application.

Waiver Priority #4: Medicaid Rate as Payment in Full

Medicaid waiver certified facilities cannot be permitted to solicit or require that a resident's family or friends make "supplemental" payments for services in addition to amounts

[2] Comment/Response Document. §2800.220, Service Provision, Response to Comment K, p. 181.

paid or authorized by Medicaid rules. It is unfair to residents, their family members, and friends to allow facilities to solicit extra payments. Such practices disadvantage residents without access to "supplemental" payments, and violate the general rule that Medicaid-authorized payments be accepted by providers as payment in full for services.[3] Pennsylvania must be clear that Medicaid waiver certified assisted living facilities are required to accept Medicaid rates as payment in full for services covered by the waiver.

Waiver Priority #5: Private Occupancy for Waiver Recipients

While private occupancy is regarded as a principal benefit of the assisted living model, the licensure regulations permit two residents to voluntarily share a living unit.[4] To ensure the residents are presented with a choice to share a room, we recommend that all waiver residents be offered a private unit, and any request to share a unit must be initiated by the resident. The Individualized Service Plan should reflect the resident's choice.

Waiver Priority #6: Fire Safety

The Commonwealth must ensure that each assisted living facility participating in the Waiver has an appropriate certificate of occupancy specifying the use and occupancy classification. A valid certificate is one that is consistent with the numbers and needs of the residents. Facilities that serve persons with mobility impairments must determine whether those individuals are capable of self-preservation. An individual who has demonstrated in fire drills that she can exit the building or go to a designated fire-safe area in an appropriate amount of time without any physical assistance and limited oral assistance is capable of self-preservation. If the facility serves any individuals who are not capable of self-preservation, that is, unable to evacuate safely in a timely manner without physical assistance and limited oral assistance, the assisted living facility must secure a certificate of occupancy that permits persons incapable of self-preservation to reside in the building. Since this is a newly implemented regulatory scheme, the Medicaid Waiver Certified facility must comply with the 2009 International Building Code (IBC) which requires an institution serving **any** persons incapable of self-preservation must be categorized as an I-2.

This is consistent with the policy developed by DPW regarding personal care homes except that, unlike personal care homes, this is a new category of building use and therefore the current codes should apply (2009 IBC). In addition, ALRs will typically house a much frailer and more vulnerable population which means greater fire protection standards should apply. Finally, there should be no "grandfathering" of certificates of occupancy held by facilities prior to their licensure as an ALR and approval as a Medicaid Waiver Certified facility.

Thank you for your consideration of these recommendations. We appreciate your conversations with the Subcommittee, our counsel, and other consumer stakeholders. We submit these recommendations to supplement those conversations. We expect additional Assisted Living

[3] See 42 C.F.R. §447.15.
[4] See Final-form Regulations for Assisted Living Licensure, 55 Pa. Code §2800.101(c).

Waiver Workgroup meetings before the submission of the waiver application to CMS. If you have questions or concerns about any of the above comments, please contact us.

Very truly yours,

Consumer Subcommittee of the MAAC
Yvette Long, Chair
Daniel Craig, Consumer Appointee on Assisted Living Priorities

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