

## **Renewal of the PDA Over-60 Waiver**

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### **Introduction**

Pennsylvania's Department of Aging Over 60 Waiver program ("PDA Waiver") provides important financial support for thousands of seniors. The program's fundamental goal is to limit nursing facility utilization and maintain elderly persons in the community for as long as possible. This year, the program will help approximately 13,000 seniors over age 60 meet their long-term care needs at home.

As a Medicaid program, the PDA Waiver receives federal funding based on the Pennsylvania federal participation percentage.<sup>2</sup> In order to obtain these federal matching funds, the program must be approved by the Centers for Medicare and Medicaid Services (CMS).<sup>3</sup> Once granted, this approval must be renewed every 5 years. Pennsylvania's PDA Waiver was last renewed in 2003. The current 5 year term will expire on June 30, 2008. Pennsylvania is preparing to apply for another 5 years of federal funding.

As part of the re-application process, the Office of Long-Term Living recently solicited oral and written comments at "Listening Sessions" held in various locations across the state. The newly formed state chapter of the National Academy of Elder Law Attorneys submitted comments, which are reproduced below.

The PDA Waiver is faced with many challenges as it enters its next renewal term. We should expect that the program will undergo significant alterations. These changes will affect the program's consumers, providers and case managers.

This article is intended to help the reader gain additional understanding of PDA Waiver program and some of the problems and pressures affecting it during this period of renewal and transition.

### **What is a Home and Community Based Services Waiver**

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<sup>2</sup> Financing for Medicaid is shared by the federal government and states and is based on the Federal Medical Assistance Percentage (FMAP) which relies on the state's relative per capita income. For fiscal year 2008 Pennsylvania's standard FMAP is 54.08%. In 2009 Pennsylvania's federal match will increase to 54.52%.

<sup>3</sup> CMS acts on behalf of the Secretary of Health and Human Services.

The Medicaid program was created in 1965 as Title XIX of the Social Security Act.<sup>4</sup> It replaced two earlier programs that provided federal grants for medical care for welfare recipients and the aged.<sup>5</sup> Under Medicaid, the federal government provides open-ended matching funds for expenditures made by the states in accordance with federal requirements.

Initially, federal Medicaid matching funds were limited to primary and acute care services. In 1968, nursing facility and other forms of institutional long term care were added. The program has since become the major government source of funding for long-term care services.<sup>6</sup> It is the ultimate safety-net for seniors who become impoverished meeting their long-term care needs.<sup>7</sup>

In 1981, Congress enacted section 1915(c) of the Social Security Act, which authorized the creation of Home and Community-based Services (HCBS) Waiver programs.<sup>8</sup> Section 1915(c) provides states with a Medicaid financed alternative to institution-based care. Congress recognized that many individuals who would otherwise be institutionalized could be cared for in their own homes and communities at a cost no higher than that of institutional care.<sup>9</sup> In the intervening years, every state has utilized Medicaid HCBS funding to cover a range of services and supports needed by people to live independently in the community.

HCBS waivers under section 1915(c) make federal funds available for services that are outside the state Medicaid plan. Waiver services can be similar to, but must not duplicate services which are provided under the state Medicaid plan.<sup>10</sup> The state must demonstrate that the cost of waiver services is not more than the cost of providing these recipients with hospital, nursing facility, or ICF/MR services which would be reimbursed under the state Medicaid plan.

Section 1915(c) gives states wide latitude to design waivers to serve specific target populations. Waivers allow states, with the approval of the Secretary of

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<sup>4</sup> Title XIX appears in the United States Code as §§1396-1396v, subchapter XIX, chapter 7, Title 42. Regulations relating to Title XIX are contained in chapter IV, Title 42, and subtitle A, Title 45, Code of Federal Regulations.

<sup>5</sup> "Green Book: Background Material And Data On The Programs Within The Jurisdiction Of The Committee On Ways And Means," Committee On Ways And Means, U.S. House Of Representatives, 2004.

<sup>6</sup> Unpaid caregiving by family and friends is the primary source of long-term care services for individuals who live at home. The annual value of this uncompensated care has been estimated to be in excess of \$250 billion per year. See, Marshall, *Elder Law in Pennsylvania, 2<sup>nd</sup> Edition* at 370.

<sup>7</sup> See, "Medicaid Home and Community-Based Service Programs: Data Update, December 2007" *Kaiser Commission on Medicaid and the Uninsured*.

<sup>8</sup> 42 U.S.C. § 1396n(c)(1); see 42 C.F.R. § 441.300 (the federal act "permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization").

<sup>9</sup> See, Marshall, *Elder Law in Pennsylvania, 2<sup>nd</sup> Edition*, Section 12-1.4

<sup>10</sup> CMS, *State Medicaid Manual*, Section 4442.1.

HHS, to implement programs that do not comply with otherwise mandatory federal Medicaid requirements.<sup>11</sup> Thus, states may restrict waiver services to certain age groups, or to people with certain kinds of disabilities, or to people residing in a specific geographic region. In addition, section 1915(c) waivers can authorize states to adopt strategies to limit the use and cost of services in ways (such as capping available slots) that would otherwise violate Medicaid standards.<sup>12</sup>

Under a waiver, states may obtain federal funding to provide a wide variety of medical, non-medical, social, and supportive services not usually provided under traditional Medicaid. Section 1915(c) thus allows states to become laboratories for experiments in delivering innovative services in a cost effective manner.<sup>13</sup>

### **Re-balancing Public Funded Long-term care**

The public funding of long term care services delivered in the recipient's home has been steadily increasing. Nationally, the proportion of Medicaid spending on HCBS more than doubled from 1992 to 2004.<sup>14</sup>

The 2008-09 Governor's Executive Budget promotes "home and community-based care as a cost effective alternative to nursing facility care with particular emphasis on transitioning nursing home residents wishing to leave a facility-based care setting and return to their home or community."<sup>15</sup> In addition to cost savings, increasing the availability of home and community-based care is seen to "promote independence and self-reliance, and maximize opportunities for family and community involvement."<sup>16</sup>

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<sup>11</sup> The Medicaid requirements are contained in Section 1902 of the Social Security Act

<sup>12</sup> Unlike mandatory or optional state plan services, HCBS waivers can have capped enrollment, which can be used by states to limit utilization. As a result, waiting lists for HCBS waivers are often long. See, Ellen O'Brien, "Long-Term Care: Understanding Medicaid's Role for the Elderly and Disabled" *Kaiser Commission on Medicaid and the Uninsured* (2005). See, also, "Olmstead v. L.C.: The Interaction of the Americans with Disabilities Act and Medicaid," *Kaiser Commission on Medicaid and the Uninsured*, June 2004, p 2-3.

<sup>13</sup> "Congress recently enacted new flexibilities as part of the Deficit Reduction Act of 2005 that give states greater ability to expand home- and community-based services to certain Medicaid beneficiaries through a state plan amendment. However, because the new state plan option includes financial eligibility limits, states will still continue to operate home- and community-based care waivers." National Governor's Association Policy Position "HHS-28, Long-Term Care," March 5, 2007.

<sup>14</sup> "Medicaid Home and Community-Based Service Programs: Data Update, December 2007", *Kaiser Commission on Medicaid and the Uninsured*. In addition to providing home and community long term care through waivers, states can choose to provide Medicaid HCBS through the mandatory home health benefit and/or the optional state plan personal care services benefit. But waivers are the primary Medicaid funding source. "In 2004, Medicaid spending on HCBS waivers was \$20.5 billion, compared to \$7.1 billion on state plan personal care services, and \$3.6 billion on home health services." *Kaiser Commission on Medicaid and the Uninsured*, "Medicaid Home and Community-Based Service Programs: Data Update, December 2007.

<sup>15</sup> The 2008-09 Governor's Executive Budget, page E33.21.

<sup>16</sup> The 2008-09 Governor's Executive Budget, page E6.7.

Although more long-term care services are being delivered in the home, Medicaid funding has remained predisposed toward institutional care. Policymakers and advocates agree that “[f]ar too often persons needing long term care receive it in a nursing home because of inadequate public funding for long term care services in the community.”<sup>17</sup> However, for the consumer in need of care, federal and state policies often continue to favor the choice of institutional care over services in home and community-based settings. In addition, non-Medicaid factors such as the lack of appropriate housing options, transportation and workforce issues, and caregiver burden and stress, can push the consumer to choose institutional care.<sup>18</sup>

This structural bias continues despite evidence that financing care in the home or community costs less on average than nursing facility care. In Pennsylvania, the current average monthly per capita cost of PDA Waiver services is only \$1,709, while the average monthly cost to Medicaid of nursing home care is \$4,321.<sup>19</sup> Nevertheless, over 70% of older Pennsylvania Medicaid recipients continue to have their long term care needs met in an institutional setting.<sup>20</sup>

Budget concerns, consumer preferences, and the 1999 United States Supreme Court *Olmstead* decision,<sup>21</sup> which held that unnecessary institutionalization constitutes illegal discrimination based on disability, have all given impetus to state and national efforts to re-balance the system so that more long term care is delivered in non-institutional settings. Overcoming Medicaid’s institutional bias and rebalancing the system to approach a 50/50 split between institutional and HCBS funding is the stated goal of the Rendell Administration.<sup>22</sup> Renewal of the PDA Waiver is one of a number initiatives intended to foster this realignment.

### **Pennsylvania’s Department of Aging Waiver**

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<sup>17</sup> “Pennsylvania Intra-Governmental Council on Long-Term Care, Home and Community-Based Services Barriers Elimination Work Group, March 2002, Revisited 2008,” available online at [www.paelderlaw.com](http://www.paelderlaw.com).

<sup>18</sup> For a discussion of institutional bias and the barriers to expansion of home and community based care, see, “Pennsylvania Intra-Governmental Council on Long-Term Care, Home and Community-Based Services Barriers Elimination Work Group, March 2002, Revisited 2008,” available online at [www.paelderlaw.com](http://www.paelderlaw.com). For a study of the existence of institutional bias in one state see “North Carolina Institutional Bias Study Combined Report,” The Lewin Group, April 2006, available at <http://www.dhhs.state.nc.us/dma/LTCReport.pdf>.

<sup>19</sup> The 2008-09 Governor’s Executive Budget, page E33.22.

<sup>20</sup> The 2008-09 Governor’s Executive Budget, page E33.22. In 2007-08 70.3% of long term care recipients received their care in an institution.

<sup>21</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).

<sup>22</sup> Commonwealth of Pennsylvania Department of Public Welfare Budget Briefing, February 5, 2008, [http://www.dpw.state.pa.us/Resources/Documents/Pdf/AnnualReports/DPWBudget\\_2008-09\\_2-5\\_Presentation.pdf](http://www.dpw.state.pa.us/Resources/Documents/Pdf/AnnualReports/DPWBudget_2008-09_2-5_Presentation.pdf).

Pennsylvania provides a continuum of support services to allow frail seniors to remain in or return to their homes and avoid an institutional setting.<sup>23</sup> Services based “on the functional and financial qualifications of the consumer [range] from home delivered meals to intensive in-home services for older Pennsylvanians needing the level of care available in institutional settings.”<sup>24</sup> Services for individuals who are not eligible for Medicaid are funded through other revenue sources such as the lottery and state general revenues. Persons with higher income or assets may be required to share in the cost of services.

The PDA Waiver is a HCBS waiver under section 1915(c) of the Social Security Act. It authorizes Pennsylvania to receive federal Medicaid matching funds to provide home and community-based services to persons age 60 and older. To qualify, individuals must be financially and clinically eligible for Medicaid nursing facility services and be able to be appropriately served in their own homes or in other community living arrangements.<sup>25</sup>

Pennsylvania’s PDA Waiver was last renewed by the Centers for Medicare & Medicaid Services (CMS) for a five-year period that ends on June 30, 2008. A renewal application is being submitted to seek funding for another five year term.

In the past, the Department of Public Welfare had overall responsibility for operating the PDA Waiver. The Waiver is currently overseen by the Office of Long Term Living, the recently created joint office of the Pennsylvania Departments of Public Welfare and Aging.

Financial eligibility is determined by local county assistance offices. Waiver operational and administrative functions, including determination of clinical eligibility, have historically been performed at the local level by area agencies on aging (AAAs).

The Pennsylvania Department of Aging has operational and administrative responsibilities including oversight of local AAAs. It develops policies and procedures for the program. Some of these can be accessed through the Department’s website [www.aging.state.pa/aging](http://www.aging.state.pa/aging). The website includes the Home and Community Based Services (HCBS) Procedures Manual which is intended to be a comprehensive guide to program procedures. Online materials are, however, frequently incomplete or out of date.

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<sup>23</sup> For a description of support services, see Eiken, Nadash, and Burwell, “Profile of Pennsylvania: A Model for Assessing a State Long-Term Care System,” Thomson Medstat, December 2006, [http://www.cms.hhs.gov/NewFreedomInitiative/Downloads/PA\\_Profile.pdf](http://www.cms.hhs.gov/NewFreedomInitiative/Downloads/PA_Profile.pdf).

<sup>24</sup> The 2008-09 Governor’s Executive Budget, page E6.7.

<sup>25</sup> The PDA Waiver was initially implemented in Philadelphia County on November 1, 1995. The program was expanded to twelve more counties effective 12/1/1996. Statewide expansion occurred October 1, 1998. See, Centers for Medicare & Medicaid Services “Home and Community-Based Services Waiver Review Report” PA HCBS Waiver for Individuals Age 60 and Over,” October 26, 2007.

Through the PDA Waiver, recipients may receive a wide array of approved services with some consumer choice as to providers. Services include “home health and personal care services, home support, attendant care, respite care, adult day care, transportation, home modifications, specialized medical equipment and supplies, counseling, extended state plan physician services, home delivered meals, personal emergency response, and companions.”<sup>26</sup> Case management and service coordination has traditionally been provided by the local AAAs, although this role may change under new federal rules discussed below.

According to a Pennsylvania report to CMS, the PDA Waiver served 14,754 individuals during fiscal 2004.<sup>27</sup> Reflecting the programs growth, the 2008-09 Governor’s Executive Budget estimates that 23,111 recipients over age 60 will receive PDA Waiver services at an average per capita monthly cost of \$1,741.<sup>28</sup>

## **Program Problems and Concerns**

Despite the general consensus among consumers and policy-makers in support of expanding home based services, the PDA Waiver program faces numerous challenges as it enters its next five years.

### **1. Meeting Federal Requirements**

#### **A. CMS Report**

During the past year, the federal government reviewed Pennsylvania’s operation of the PDA waiver.<sup>29</sup> CMS found that Pennsylvania had improperly made modifications to program operations in the area of Level of Care (LOC) and intake procedures without federal approval.<sup>30</sup> In addition, CMS found that Pennsylvania lacks a uniform, statewide, rate-setting methodology. These issues, and other concerns and suggestions raised in the CMS report, will have to be addressed in the renewal application.<sup>31</sup>

#### **B. Targeted Case Management Interim Rules**

New regulations issued by CMS have the potential to force extensive reconstruction of the operation and administration of the PDA Waiver. Unless

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<sup>26</sup> Description from Pennsylvania Department of Aging website, at <http://www.aging.state.pa.us/aging/cwp/view.asp?a=284&q=173701>.

<sup>27</sup> Centers for Medicare & Medicaid Services “Home and Community-Based Services Waiver Review Report” PA HCBS Waiver for Individuals Age 60 and Over,” October 26, 2007.

<sup>28</sup> The 2008-09 Governor’s Executive Budget, page E33.22.

<sup>29</sup> Centers for Medicare & Medicaid Services “Home and Community-Based Services Waiver Review Report PA HCBS Waiver for Individuals Age 60 and Over,” October 26, 2007.

<sup>30</sup> The LOC changes have been a particular area of contention between elder law attorneys and other advocates and the Department of Aging. See further discussion below.

<sup>31</sup> The CMS report is available at [www.paelderlaw.com](http://www.paelderlaw.com).

blocked by Congress, the Interim Targeted Case Management Rule is set to take effect on March 3, 2008.

Case management helps individuals gain access to needed medical and support services. The term “targeted case management services” means case management services that are provided to targeted populations without regard to state-wideness and comparability requirements.

The Deficit Reduction Act of 2005 (DRA) re-wrote Medicaid’s definition of case management and placed new limits on the services that are reimbursable. The Interim Rule<sup>32</sup> was issued by CMS under authority of section 6052 of the DRA.<sup>33</sup> However, CMS’ implementation of the DRA as set forth in the Interim Rule is being criticized as going well beyond Congressional intent.

Pennsylvania currently receives Medicaid funding for case management services provided by local AAAs in regard to Waiver services. The state is able to use 180 days of case management services to help transition Medicaid beneficiaries from nursing facilities to home and community based care.

Changes mandated by the Interim Rule would greatly reduce Pennsylvania’s receipt of federal matching funds for Waiver related case management services. These changes include:

- Reduction of the 180 days of case management coverage to a maximum of 60 days (and even less for short stays in an institution). And Medicaid reimbursement will not be available unless and until an individual successfully transitions to the community.

- Imposition of a fixed limit of one case manager per person, without regard to the multitude of conditions that may affect an individual. That single case manager will have to attempt to manage services across complex morbidities and service systems.

- Limitation of prior state flexibility in payment methodologies. The Interim Rule requires states to follow a payment determination rate familiar to lawyers - based on 15 minute increments.

- Opening case management to competition. In Pennsylvania, case management for the PDA Waiver is reimbursed as an administrative activity with the local area agencies on aging (AAAs) serving as the required case management provider. Level of care determinations are made by the AAA case managers with oversight by the Pennsylvania Department of Aging. Under the Interim Rule, consumers must be offered a choice of case managers (and may even choose to have no case manager). In addition, case managers will no longer be permitted to make level of care determinations.

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<sup>32</sup> Federal Register, December 4, 2007, Vol. 72, No. 232, 68077-68093. To view the rule, visit [http://www.cms.hhs.gov/MedicaidGenInfo/08\\_Medicaidregulations.asp](http://www.cms.hhs.gov/MedicaidGenInfo/08_Medicaidregulations.asp).

<sup>33</sup> Amending 42 U.S.C. § 1396n(g)(2).

These changes, if implemented, will force Pennsylvania to dramatically restructure the way the PDA Waiver is administered. The Department of Public Welfare, the Pennsylvania Association of Area Agencies on Aging, home care providers and elder law attorneys have all raised concerns that the Interim Rule will have serious negative consequences for the delivery of services under the PDA Waiver and other programs. Strong opposition has also been expressed by other state and national organizations and the National Governor's Association.<sup>34</sup>

DPW has requested that CMS delay the implementation of the new rule. The National Governor's Association has asked Congress to step in to prevent the imposition of the new Rule. Congress has imposed moratoriums on other recent Bush administration attempts to pursue substantive changes like these via regulation, and delay is quite possible.

## **2. State Imposed Restructuring**

### **A. Thomson Medstat Reports**

In July 2005, DPW contracted with Thomson Medstat, the world's largest professional healthcare information services provider, to evaluate Pennsylvania's long-term living programs, and to suggest ways to better manage cost and quality. Special emphasis was placed on the structure of the state's Medicaid home and community-based services (HCBS) waiver programs.

At approximately the same time, CMS engaged Thomson Medstat to develop a technical assistance guide that all states could use to create a profile of their long-term care systems. Pennsylvania was chosen as the research subject in developing the guide.

As a result of these endeavors, Thomson Medstat issued two important reports on the Pennsylvania long term care system.<sup>35</sup> A March 2006 report titled, "Home and Community Based Services Reform and Rebalancing Feasibility Analysis Final Report," recommended that the state consider a number of structural changes to Pennsylvania's existing system of delivering home and community based services. These recommendations appear to sketch many of the actions being pursued by the Office of Long Term Living.

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<sup>34</sup> See, Robert Pear, "Governors of Both Parties Oppose Medicaid Rules," New York Times, February 24, 2008.

<sup>35</sup> "Home and Community Based Services Reform and Rebalancing Feasibility Analysis Final Report," Thomson Medstat, March 24, 2006, [http://www.paproviders.org/Pages/MR\\_Archive/HCBS\\_Feasibility\\_Study\\_MedStat.pdf](http://www.paproviders.org/Pages/MR_Archive/HCBS_Feasibility_Study_MedStat.pdf); Eiken, Nadash, and Burwell, "Profile of Pennsylvania: A Model for Assessing a State Long-Term Care System," Thomson Medstat, December 2006, [http://www.cms.hhs.gov/NewFreedomInitiative/Downloads/PA\\_Profile.pdf](http://www.cms.hhs.gov/NewFreedomInitiative/Downloads/PA_Profile.pdf).

The Thomson Medstat findings and recommendations for Pennsylvania's waiver programs (not limited to the PDA Waiver) included:<sup>36</sup>

1. Realignment of management structures to link management authority and fiscal responsibility.
2. Centralized administration of waiver programs and strengthened state oversight of local waiver program operations and quality monitoring activities.
3. Development of a uniform assessment process.
4. Streamlining the eligibility process for applicants at most risk of institutional services.
5. Prioritization of waiver services for persons most at risk.
6. Development of residential service components in waiver programs.
7. Increased continuity in case management services.
8. Separation of case management services from direct service provision.
9. Consolidation of several waiver programs (not including the PDA Waiver).
10. Broadening waivers to serve additional population targets.

## **B. Assessments and Level of Care**

In order to qualify for PDA waiver benefits, an applicant must be determined to require the level of care of a nursing facility.<sup>37</sup> This determination is based on a medical evaluation conducted by the applicant's physician, and an assessment conducted by the local area agency on aging. The level-of-care (LOC) criteria are complex, involving multiple measures of functional and nursing needs.

In 2006, the Department of Aging revised the assessment process in order to enhance statewide "consistency" in assessments and increase centralized control over the availability and utilization of Waiver. It issued a new standardized tool for assessing clinical eligibility for Medicaid funded nursing facility and waiver services.<sup>38</sup> In addition, the Department revised and tightened the criteria for functional qualification for Medicaid. These changes effectively limited eligibility for Waiver benefits, resulted in frequent delays in approvals, and made planning much more difficult.

As discussed below, the Department's new functional need criteria appear to be in contravention of federal Medicaid law.<sup>39</sup> In addition, the assessment and level of care changes were implemented without being submitted to CMS for approval.

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<sup>36</sup> See, "Home and Community Based Services Reform and Rebalancing Feasibility Analysis Final Report," Thomson Medstat, March 24, 2006, [http://www.paproviders.org/Pages/MR\\_Archive/HCBS\\_Feasibility\\_Study\\_MedStat.pdf](http://www.paproviders.org/Pages/MR_Archive/HCBS_Feasibility_Study_MedStat.pdf)

<sup>37</sup> 42 U.S.C. § 1396n(c)(1).

<sup>38</sup> The 12 page level of care assessment (LOCA) tool is available online at [http://www.aging.state.pa.us/aging/lib/aging/loca\\_feb\\_16\\_2007.pdf](http://www.aging.state.pa.us/aging/lib/aging/loca_feb_16_2007.pdf).

<sup>39</sup> See discussion of federal level of care requirements in *Maryland Department of Health and Mental Hygiene v. Ida Brown*, 935 A.2d 1128 (Md. Ct. Special Appeals, November 27, 2007) available at <http://mdcourts.gov/opinions/cosa/2007/1572s06.pdf>.

Prior to the 2006 changes, the Department of Aging Assessment Manual mirrored federal law by specifying that functional eligibility for the Waiver requires a medical diagnosis/illness or condition, which creates medical needs for care and service, which:

- Are ordered by, and provided under the direction of a physician, and;
- Are needed to be given on a regular basis and provided by or under the supervision of a skilled medical professional, **or**
- Because of a mental or physical disability, the individual requires nursing and related health and medical services in the context of a planned program of health care and management.

These services are usually only available in an institutional setting.  
[Emphasis added]

The Department's above stated pre-2006 definition of nursing facility clinical eligible (NFCE) status was consistent with federal Medicaid requirements that eligibility be granted not only to consumers who need "skilled care" but also to applicants in need of what used to be called "intermediate care."<sup>40</sup>

On March 28, 2007 the Department of Aging formally revised the Home and Community Based Services Assessment Manual with the issuance of Aging Program Directive APD # 07-01-01.<sup>41</sup> The APD re-defined an NFCE consumer as follows:

A NFCE consumer is an individual who is assessed and determined to be clinically eligible for NF care. This determination is made based on the diagnosis by a physician of a medical illness or condition which creates medical needs that require care and service, which:

- Are ordered by, and provided under the direction of a physician, and;
- Are needed to be given on a regular basis and provided by or under the supervision of a skilled medical professional, **and**
- Because of a mental or physical disability, the individual requires nursing and related health and medical services in the context of a planned program of health care and management.

These services are usually only available in an institutional setting.  
[Emphasis added]

The change of the word "or" to "and" imposes a skilled care requirement for NFCE status and effectively deletes coverage for consumers who need only an intermediate level of care. As a result, the Department has set the standard for eligibility higher than federal law permits in violation of Section 42 U.S.C. § 1396r(a).<sup>42</sup>

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<sup>40</sup> Prior to The Nursing Home Reform Law of 1987, Medicaid law categorized nursing homes into two levels - skilled care and intermediate care facilities. The Reform Law abolished the distinction effective October 1, 1990.

<sup>41</sup> Available online at the Department of Aging website <http://www.aging.state.pa.us/aging/>.

<sup>42</sup> See, 42 U.S.C. § 1396r(a)(1)(C); 42 C.F.R. § 440.155. "Plainly, 42 C.F.R. § 440.155 does not require involvement of, or service provided by, skilled or trained medical personnel.' *Maryland*

Pennsylvania's current non-compliance with federal level of care requirements will need to be addressed in the Waiver renewal.

### **3. Quality Concerns**

Seniors who are nursing home clinically eligible are a particularly vulnerable population. As we redirect public funding from institutional care to home based care, a primary concern should be the quality and safety of community delivered services.

For decades, Medicare and Medicaid funded nursing facilities have been subject to stringent regulations and surveys intended to help ensure the delivery of quality care. But similarly rigorous quality assurance standards and enforcement mechanisms do not yet exist with regard to the services delivered in homes under PDA waiver. To some extent the home setting precludes the level of oversight found in nursing facilities. Quality problems such as lack of reliability, negligent or untimely care, poor attitudes, theft, neglect, and abuse may be much more difficult to discover in the home environment.

A 2003 U.S. Government Accountability Office (GAO) report found significant quality problems in many Medicaid HCBS waiver programs.<sup>43</sup> Common problems included:

- Clinical staff with inappropriate credentials or training to provide care;
- Case managers who were under-qualified and inexperienced;
- Authorized or necessary services that were not provided;
- Plans of care that did not include adequate assessment or documentation of the recipient's care needs;
- Medication administration which was not sufficiently documented in records, raising concerns that medication was not dispensed safely or by qualified staff in some programs, and
- Insufficient available staff.

After the issuance of the GAO report, CMS increased its focus on state waiver program quality assurance systems; and, in the DRA, Congress ordered the development of quality of care measures that can be used to assess Medicaid HCBS programs. The goal is development of the ability to perform comprehensive, standardized assessments of quality of care in Medicaid home and community based services. A related endeavor is the creation of a combined

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*Department of Health and Mental Hygiene v. Ida Brown*, 935 A.2d 1128 (Md. Ct. Special Appeals, November 27, 2007) available at <http://mdcourts.gov/opinions/cosa/2007/1572s06.pdf>.

<sup>43</sup> "Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers should be Strengthened," U.S. Government Accountability Office, GAO-03-576, June 2003.

patient assessment instrument that can be used across institutional and home care settings.<sup>44</sup>

In its October 2007 Pennsylvania report, CMS found that “[w]hile the State does engage in discovery activities designed to monitor Waiver program quality within individual provider agencies, there is not currently a strategy to analyze the results in aggregate form, or develop systemic remediation strategies to improve overall Waiver program quality.”<sup>45</sup> In addition, CMS noted that Pennsylvania needs to improve its system of assuring the health and welfare of waiver participants including identification, remediation and prevention of abuse, neglect and exploitation.

As part of the renewal application, Pennsylvania will be required to address these CMS concerns and develop a comprehensive strategy to improve overall Waiver program quality. While Pennsylvania will be working on systemic improvements in quality assurance, the task of developing a system that can comprehensively evaluate and monitor the quality of care being delivered to PDA Waiver recipients in their homes is formidable.

#### **4. Barriers to Expansion**

For numerous reasons, access to Medicaid coverage for PDA Waiver services is more difficult and restricted than access to nursing home care. Impediments to more effective consumer utilization of waiver services is documented in a report originally prepared by a workgroup of the Pennsylvania Intra-Governmental Council on Long Term Care in 2002, and revised in 2008.

“The Workgroup found approximately 22 barriers that relate to lack of information and knowledge about HCBS, the stigma attached to receiving publicly funded HCBS, complexities and delays in establishing functional and financial eligibility for publicly funded HCBS, insufficient services for certain geographic or functional populations, unavailability of affordable housing, shortages in the workforce, and lack of quality assurance.”<sup>46</sup>

If the state’s desired re-balancing is to succeed, it will need to more effectively address the informational, procedural, and systemic barriers described in the Workgroup report.

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<sup>44</sup> Kasper, et al, “Long-Term Services and Supports: The Future Role and Challenges for Medicaid,” Kaiser Commission on Medicaid and the Uninsured, September 2007.

<sup>45</sup> “CMS Report of Review of PA HCBS Waiver for Individuals Age 60 and Over, October 26, 2007,” available at [http://www.paelderlaw.com/pdf/CMS\\_Report\\_PA\\_HCBS.pdf](http://www.paelderlaw.com/pdf/CMS_Report_PA_HCBS.pdf). The quality assurances that must be submitted by Pennsylvania are described in Appendix H of the Waiver Renewal Application, Application for a §1915(c) Home and Community-Based Waiver [Version 3.3] Instructions, Technical Guidance Review Criteria Release Date: November 2005.

<sup>46</sup> “Home & Community Based Barriers Elimination Work Group Report 2002, Revisited 2008,” Pennsylvania Intra-Governmental Council on Long Term Care, pp 1-2. A copy of the updated report is available online at: [http://www.paelderlaw.com/pdf/HCBS\\_barriers\\_revisited.pdf](http://www.paelderlaw.com/pdf/HCBS_barriers_revisited.pdf)

## **Conclusion**

For the foreseeable future, Medicaid will remain the primary public financing system for long-term services and supports. The trend towards providing more of those services in the home will continue. Cost concerns will dominate policy decisions made in regard to home care expansion, but many other issues need to be addressed if we are to create a system that will provide cost-effective high quality home and community services to our vulnerable seniors. Cost, access and quality will remain key areas of concern.

## **PAELA's Comment Submission on the PDA Waiver Renewal**

### **Pennsylvania Association of Elder Law Attorneys**

*A State Chapter of the National Academy of Elder Law Attorneys*

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February 6, 2008

Office of Long Term Living  
Attention: Listening Sessions  
P.O. Box 2675 Harrisburg, PA 17105

Submitted via email to [ra-acwrenewal@state.pa.us](mailto:ra-acwrenewal@state.pa.us)

Re: Listening Session Written Comments regarding PA Aging Waiver (Home and Community-Based Services Waiver of Individuals Age 60 and Over) renewal.

Thank you for this opportunity to comment on the renewal of the Pennsylvania Aging Waiver.

The Pennsylvania Association of Elder Law Attorneys (PAELA) is an association of elder law attorneys who represent aging consumers in Pennsylvania. PAELA attorneys serve many consumers who qualify for Medicaid funded long term care services through Home and Community Based Services Waiver programs. Our members help families with the problems they encounter in attempting to access needed services in the home. We believe our consumer oriented perspective gives us a singular ability to assist the Office of Long Term Living in re-balancing the long term care delivery system. We welcome any opportunity to do so.

Although operational statewide in Pennsylvania for nearly 10 years, the success of the Aging Waiver has been impeded by complication, confusion, dysfunctional limitations, and delay. Delay is particularly destructive since the need for services is usually immediate, but immediate delivery is generally available only in an institution. As a result, the program has failed to fully realize its

potential in helping the state realign the delivery of Medicaid funded long term living services away from its traditional institutional bias.

We encourage the state to view the renewal application as an opportunity to improve access to Aging Waiver services. PAELA requests that the Office of Long Term Living consider the following recommendations in preparing its renewal application.

(1) The PA waiver renewal application should include coverage for intermediate care as “ordered by or provided under the direction of a physician under circumstances where, because of a mental or physical disability, the individual requires nursing and related health and medical services in the context of a planned program of health care and management.”

The Department of Aging's recent imposition of a skilled care limitation for eligibility (APD #07-01-01 issued March 28, 2007) is not only inconsistent with federal standards, it also has reduced access to Waiver services, impacted the quality of care, increased reliance on solely state funded assistance, and increased the risk of consumer institutionalization. Pennsylvania should return to utilizing level of care eligibility criteria that include both skilled and intermediate care.

(2) The application should seek to implement the recommendations of the “PA Intra-Governmental Council on Long Term Care’s Home and Community-Based Barriers Elimination Work Group Report 2002” as updated in January 2008. A copy of that report is attached. Little has yet been done to eliminate wholly the 22 barriers identified six years ago and the state must not let this opportunity to do so pass it by.

(3) Pennsylvania should seek to exempt the Aging Waiver from the recently proposed Targeted Case Management (TCM) rules (72 Fed. Reg. 68077). Some of the TCM rule changes appear to go well beyond the requirements of the Deficit Reduction Act. Privatization of case management services will add to the delays already plaguing the home delivery system and will undermine the local area agencies of aging’s ability to protect elderly Medicaid eligible consumers from neglect, abuse, and fraudulent activity.

The proposed TCM rules will also impede efforts to transition consumers from institutional to home and community settings. The reduction of Medicaid transition services from 180 days of coverage to only 60 days would indisputably limit the ability of consumers to transition home from institutional settings and further obstruct rebalancing efforts.

Consumer “freedom of choice” of case management provider (and the ability to choose no provider) will further fragment access to Aging Waiver services and limit Pennsylvania’s ability to control and streamline their delivery. To improve access and utilization, the program needs simplification rather than further fragmentation.

Pennsylvania’s Aging Waiver renewal application should seek an exception for this program from the new TCM rules at least until Pennsylvania can integrate the TCM changes into a comprehensive strategy that supports the shift from institutional to home and community-based care. If the Aging Waiver cannot be exempted from the interim TCM rules, the implementation of those rules should be delayed until they can be effectively implemented as part of Pennsylvania’s overall re-balancing strategy.

Please feel free to contact either Marielle Hazen or Jeffrey Marshall at the addresses below if you have any questions or need clarification regarding these comments.

Sincerely,

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