National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

WHITE PAPER

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Medicaid Payment for Assisted Living

Preventing Discrimination against Medicaid-Eligible Residents

Introduction

Medicaid has been paying for assisted living services for over twenty years, either through Home and Community-Based Services (HCBS) waivers, demonstration waivers, or state-plan services. At least some Medicaid funding for assisted living is available in 45 states, including the District of Columbia.

To this point, the federal government has not established standards for Medicaid-certified assisted living facilities. State rules vary but resident protections tend to be limited. Despite growth in federal and state expenditures for assisted living, there has been scant public policy attention to how Medicaid funding for assisted living actually works in practice.

With years of experience, a variety of state models, and the prospect of further program growth, now is an appropriate time for policy makers and advocates to look critically at how well Medicaid-funded assisted living is working for Medicaid-eligible residents, and to identify appropriate consumer protections to rectify existing problems.

The National Senior Citizens Law Center (NSCLC) recently undertook an extensive study of federal and state Medicaid policies towards assisted living, with a focus on how those policies impact the lives of assisted living residents.[1] The study and the development of this paper were supported by The Commonwealth Fund.

The results of this study are laid out in a series of policy issue briefs that will be released by NSCLC from Fall 2010 through Spring 2011. Each of these policy issue briefs discusses problems with the status quo, and makes recommendations for change. In many instances, a policy issue brief has a companion white paper that discusses the same issues in greater detail.

This paper is one of the companion white papers, providing more detail on discrimination against

1 The research included a survey of respondents in the 37 states that pay for assisted living service through a Medicaid Home and Community-Based Services waiver, as well as more in-depth research of policies and practices in five of those states: Arkansas, New Jersey, Oregon, Texas, and Washington. The research was conducted in cooperation with the University of California at San Francisco. This paper, however, is written by the National Senior Citizens Law Center, which is solely responsible for the findings, opinions, and recommendations expressed herein.

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Medicaid-eligible residents in assisted living facilities. Both this white paper and the accompanying policy issue brief are available at NSCLC's website, www.nsclc.org.

Discrimination Against Medicaid-Eligible Residents Leads to Residents' Eviction

This paper examines three interrelated practices of Medicaid-certified assisted living facilities. Each of these practices discriminates against Medicaid-eligible residents, limiting their access to Medicaid-covered services. These practices are:

- Requiring private payment from a resident for a specified number of months as a condition of subsequently accepting Medicaid reimbursement for that resident's care;
- Refusing to accept Medicaid for a resident's care when that resident is attempting to convert from private payment to Medicaid eligibility; and
- Withdrawing from Medicaid and then evicting Medicaid-eligible residents.

Notably, each of these practices is inconsistent with the practices of other Medicaid-certified providers. In general, for example, a Medicaid-certified hospital, physician or clinic is required to accept Medicaid reimbursement from a Medicaid-eligible patient. Regardless, at this time, the federal Centers for Medicare and Medicaid Services (CMS) does not explicitly address these practices in assisted living facilities. Furthermore, state regulation is minimal, with only a small minority of states that have adopted explicit consumer protections against these discriminatory practices in assisted living facilities.

Vulnerable Medicaid beneficiaries need protection from exploitation and dislocation. This paper recommends that, as a condition of Medicaid certification, assisted living facilities must:

- Not require private payment of any duration as a condition of accepting Medicaid reimbursement for the resident.
- Accept Medicaid reimbursement whenever a resident becomes Medicaid-eligible and attempts to transfer from private payment to Medicaid coverage.
- Even after voluntary decertification, continue to accept Medicaid reimbursement from all Medicaid-eligible residents who resided in the facility at the time of decertification.

These protections can be put in place by either state or federal action, although federal action would create more uniform protections. With establishment of these protections, Medicaid-funded assisted living would be more consistent with other Medicaid-reimbursement health care services, where it is a long-accepted principle that a Medicaid-certified provider must accept Medicaid reimbursement from an eligible patient.

I. REQUIRING PRIVATE PAYMENT BEFORE ACCEPTING MEDICAID REIMBURSEMENT

The Issue: Residents in Medicaid-certified assisted living facilities commonly face facility–imposed requirements that the residents pay privately for a certain number of months or years before the facility will accept Medicaid coverage from the resident. Furthermore, even when the required private payments are made, residents have no firm assurances that, when they run out of money and qualify financially for Medicaid, the facility will accept their Medicaid reimbursement.

Policy Recommendations: Medicaid-eligible assisted living residents need and deserve the same protections as Medicaid beneficiaries receiving other types of health care services. Facilities that have obtained Medicaid certification should be required to accept Medicaid payment without limitation or precondition from Medicaid-eligible residents.

Current Federal Requirements: Federal Medicaid law requires that a Medicaid-certified provider—for example, a Medicaid-certified physician—must accept Medicaid reimbursement from a Medicaid-eligible patient, and cannot bill the patient for any more than the cost-sharing allowed by Medicaid law.[2] This provision, even prior to the enactment of the Nursing Home Reform Law, was used successfully in private litigation to challenge a private-payment precondition imposed by a nursing facility.[3] The provision could support a lawsuit challenging an assisted living facility's private-payment precondition, but no suits have been brought to this point, to the best of our knowledge. Residents generally are unaware of the relevant Medicaid law.

The federal Nursing Home Reform Law, enacted in 1987, explicitly prohibits a nursing facility from requiring a resident to waive her right to Medicaid coverage.[4] Federal law, however, does not specifically address this issue in regard to assisted living.

State Practices: Anecdotal reports suggest that persons entering assisted living facilities sometimes face demands from the facility that they commit to private-pay periods of a year or more.

Neither CMS nor the states generally require facilities to report such requirements, so little to no empirical information is available.

New Jersey is an exception, as it has required assisted living facilities to prepare disclosure statements on certain issues relating to Medicaid coverage. These disclosure statements are required to be provided to consumers and also submitted to the New Jersey Department of Health and Senior

2 42 C.F.R. § 447.15.

3 Glengariff Corp. v. Snook, 471 N.Y.S.2d 973, 978 (N.Y. Sup. Ct. 1984); *see also* Berry v. First Healthcare Corp. (D. N.H 1977), reprinted in Medicare & Medicaid Guide (CCH) P 28,693 (class action allegations based on facility practice of transferring residents who became Medicaid-eligible within two years after admission); 1985 Ohio AG LEXIS 39, Ohio Att'y Gen. Op. No. 85-063 (private-pay requirement illegal under state law).

4 42 U.S.C. § 1396r(c)(5)(A)(i).

Services.[5] This study made a request for these disclosure statements under New Jersey's Open Public Records Act, and in return received copies of 77 disclosure statements.

The disclosure statements showed that forty-five percent of the facilities required private payment as a precondition for Medicaid eligibility. Furthermore, the private-pay requirements were significant. Of the facilities requiring private payment, 47 percent required private payment for 19 to 24 months. Another 18 percent required payment for 25 or more months. All told, a full 82 percent of the facilities required private payment for ten months or more—a significant obligation, given the expense of assisted living care.

These results are consistent with findings of a recent investigation conducted by the New Jersey Public Advocate into the business practices of one assisted living chain, Assisted Living Concepts (ALC). That investigation concluded that many ALC residents were required to pay privately for at least one year as a condition of the facility accepting Medicaid reimbursement. The Public Advocate also found that residents and family members inferred from the agreements that the facility committed itself to accepting Medicaid reimbursement if the resident became eligible after paying privately for the designated period of time, but that inference often was incorrect, as the facility ultimately refused to accept Medicaid. Thus, the resident's commitment to private payment for a certain number of months not only limited the resident's right to use Medicaid reimbursement, but also misled the resident and resident's family as to the facility's obligations towards the resident.[6]

A similar situation was reported by a consumer representative from *Washington* during an interview conducted by the study. The consumer representative reported that facilities in that state imposed minimum private pay period requirements without necessarily committing themselves to accepting Medicaid reimbursement at the end of the designated time.

The *Ohio* Medicaid program itself requires that a resident pay privately for six months before accessing Medicaid payment for assisted living services, although a person also can be eligible for coverage by currently living in a nursing facility, or currently using waiver benefits for pay for in-home care.[7] It appears that the purpose of this requirement is to assure that assisted living care truly is necessary. The requirement discriminates, however, on the basis of financial resources, by favoring the person who spends down in the assisted living facility to Medicaid-eligible levels, over the person who has been Medicaid-eligible for some time.

In contrast to the general state permissiveness around private pay requirements, *Oregon* protects residents by forbidding an assisted living facility from requiring a certain amount of private payment as a precondition for Medicaid coverage. The policy was set forth in a 1997 letter from a state official to assisted living providers.[8]

5 N.J. Dep't of Health & Sen. Servs., Div. of Aging & Community Servs., Policy Memorandum # 2004-5, VIII-1, Disclosure of Assisted Living Facilities' Medicaid Policies (July 30, 2004).

6 N.J. Dep't of Pub. Advocate, Aging in Place: Promises to Keep, An Investigation into Assisted Living Concepts, Inc. and Lessons for Protecting Seniors in Assisted Living Facilities 29 (2009).

7 Ohio Rev. Code Ann. § 5111.891.

8 Letter from Susan L. Dietsche, Assistant Administrator of Senior and Disabled Services Division of the Oregon Department of Human Resources, to Assisted Living Providers and Owners (July 18, 1997).

Going Forward: Medicaid coverage exists in order to provide necessary health care to low-income persons who otherwise could not afford the necessary care. But this protection is weakened, and to a certain extent eviscerated, when a Medicaid-certified provider is allowed to refuse Medicaid coverage. The effect on a Medicaid-eligible assisted living resident is particularly harsh because refusal of coverage leads inexorably to eviction, given the resident's limited financial resources.

Medicaid-certified facilities should be required to accept Medicaid coverage from any Medicaid-eligible resident, and thus prohibited from requiring private payment as a precondition to using Medicaid eligibility. If facilities contend that Medicaid's reimbursement rate, or room and board allocation is inadequate, that should be addressed at the appropriate policy levels, rather than having vulnerable residents being left in the lurch. Closing the door on needy residents by setting financial entrance requirements is inconsistent with Medicaid certification and discriminates inappropriately among Medicaid beneficiaries.

II. RESERVING THE RIGHT TO REFUSE MEDICAID REIMBURSEMENT FROM EXISTING RESIDENTS

The Issue: Some Medicaid-certified assisted living facilities refuse to accept Medicaid reimbursement from certain residents who have just become Medicaid-eligible. Facilities either assert that no Medicaid-certified beds are available or simply refuse Medicaid reimbursement without any specific justification.

Policy Recommendations: As a condition of Medicaid certification, assisted living facilities should be required to accept Medicaid from current private-pay residents who spend down to Medicaid eligibility. Likewise, facilities should be prohibited from imposing any absolute or percentage limits on the number of Medicaid-eligible residents. Admission contracts should be required to clearly state that a resident converting to Medicaid has the right to remain in the facility.

The federal and state governments should establish monitoring and enforcement mechanisms to protect against eviction of Medicaid-eligible residents on pretexts.

Current Federal Requirements: Neither federal regulations nor HCBS waiver requirements specifically address the duty of Medicaid-certified assisted living facilities to accept Medicaid reimbursement from residents transitioning from private payment to Medicaid coverage.

In nursing facilities, by contrast, a Medicaid-certified facility is required to accept Medicaid reimbursement from a resident. This protection is compromised in part, however, by partial certification, i.e., certification of only a certain percentage of a facility's beds in a "distinct part" of the facility. In a partially certified facility, the facility is required to accept Medicaid reimbursement from a resident in the certified area, but not from a resident in the uncertified area. Some states demand inclusion of all beds in Medicaid certification of nursing facilities, but a significant number of other states allow certification of only a portion of a facility's beds, as allowed by the federal nursing facility law.

State Practice: In most states, this issue currently is not addressed explicitly. In practice, the failure to address this issue translates to Medicaid-certified facilities having the discretion to refuse Medicaid reimbursement. As described below, a minority of states have enacted limited protections for residents.

Minnesota law does not address the issue. This study made phone calls to inquire about the Minnesota program, and a state respondent said that some facilities have general policies of not necessarily accepting Medicaid reimbursement from resident who has spent down to Medicaid eligibility levels.

New Jersey requires only that a facility disclose its policy on this issue to applicants.[9] On the other hand, when a facility submits a referral form to the Medicaid program for a particular resident, the facility commits to accepting the resident as a Medicaid-reimbursed resident as soon as program eligibility is determined.[10] Legislation was proposed in New Jersey to require an assisted living facility to accept Medicaid reimbursement from any currently Medicaid-eligible resident, but this legislation was not enacted.[11]

A few states, as described below, formally follow partial-certification policies. Such policies are a mixed bag for consumers. On the one hand, partial certification guarantees that a facility will be required to accept Medicaid reimbursement from specified beds within the facility. On the other hand, the facility is prevented from accepting Medicaid reimbursement from a resident in the facility's uncertified area.

For example, *Texas* requires that a certified facility designate a specific number of units for certification.[12] According to a state respondent, a facility can retain its certification as long as it serves even just one Medicaid-reimbursed resident within a six-month period.

On the other hand, Texas has a noteworthy protection for persons referred to a facility by the state. In such cases, the burden is placed on the facility to justify any refusal to accept Medicaid reimbursement, with the only legitimate excuses being the facility's lack of capacity, or the applicant having care needs exceeding the facility's capabilities. For a refusal based upon a care-needs justification, the applicant has the right to appeal to an interdisciplinary team comprised of the resident and/or resident's representative, a facility representative, and a Texas Department of Health Services representative.[13]

Arkansas also allows partial certification of Medicaid beds. An Arkansas state respondent said that residents generally faced eviction if a "Medicaid bed" was not available when a resident spent down to Medicaid-eligible levels.

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9 N.J. Dep't of Health & Sen. Servs., Div. of Aging & Community Servs., Policy Memorandum # 2004-5, VIII-1, Disclosure of Assisted Living Facilities' Medicaid Policies (July 30, 2004).

10 N.J. Dep't of Human Servs., Medicaid Communication 01-18 (Sept. 13, 2001); N.J. Dep't of Health & Sen. Servs., N.J. Provider Manual for Medicaid Assisted Living Facilities and Programs, at 5, 20 (2002).

11 N.J. S. 2066 (2008).

12 40 Tex. Admin. Code § 46.11(b)(3).

13 40 Tex. Admin. Code §§ 46.11(d), 46.35(a).

Georgia has better beneficiary protections, based on the description by a state respondent. The state requires that a potential waiver beneficiary live and receive services in the facility prior to any eligibility determination. A care manager assists in the Medicaid application process. During the pendency of the application, the resident pays only the room and board allotment and the estimated Medicaid share of cost. After eligibility is determined, the facility must accept Medicaid reimbursement.

Illinois, New Hampshire, and Oregon offer the strongest consumer protections, requiring that facilities accept Medicaid from existing residents who become qualified for the benefit. The *Illinois* policy evidently is based on state regulations that define a "Medicaid resident" as someone who has been determined to be eligible for Medicaid reimbursement of supportive living facility services.[14]

The *New Hampshire* policy is founded on a "Patient's Bill of Rights" that applies to residents of hospitals, nursing homes, assisted living facilities, and other such settings. Under one of these rights, "[n]o patient shall be involuntarily discharged from a facility because the patient becomes eligible for [M]edicaid as a source of payment."[15] After citing this law, however, one New Hampshire state respondent went on to note that "[i]n practice, most facilities that accept Medicaid payment limit the number of Medicaid-eligible residents they have at any given time."

In *Oregon*, the Medicaid provider agreement states that the "Contractor shall not designate specific units or areas of its Assisted Living Facility for Medicaid-Eligible Individuals served under this Contract."[16] A respondent reported that a facility must accept a resident's Medicaid coverage, and that certification generally applies to an entire facility. Nonetheless, a resident can be required to move from a private apartment to a studio when becoming Medicaid-eligible, since the Medicaid room and board allocation is based on a studio.

Going Forward: In most states, assisted living residents do not have the security of knowing, if and when they qualify for Medicaid, whether their Medicaid-certified facility will allow them to stay. Although many assisted living facilities choose to accept Medicaid from private-pay residents who have spent down to Medicaid eligibility, few states compel the facilities to do so. If assisted living is to play a significant part in Medicaid-funded home and community-based services, Medicaid-certified facilities should be required to accept Medicaid reimbursement when it is offered. Medicaid-eligible assisted living residents deserve stability in both their housing and health care.

14 Ill. Admin. Code tit. 89, §§ 146.205, 146.225

15 N.H. Rev. Stat. Ann. § 151:21; *see* N.H. Rev. Stat. Ann. §§ 151:2 (facilities subject to law), 151:19 (definitions).

16 Ill. Admin. Code tit. 89, §§ 146.205, 146.225.

III. WITHDRAWING FROM MEDICAID WITHOUT PROTECTIONS FOR RESIDENTS

Issue: When a facility withdraws from the Medicaid program, Medicaid-eligible residents often face mass evictions, sometimes with only a month's notice. Furthermore, private-pay residents face the prospect of having to leave once they spend their resources down to Medicaid eligibility levels, even though they had moved in expecting that a transition to Medicaid coverage would be available.

Policy Recommendations:

- State Medicaid agencies should continue to make Medicaid reimbursement available into the future for Medicaid-eligible residents who resided in an assisted living facility at the time the facility withdrew from Medicaid.
- Even after withdrawal, facilities should be required to accept Medicaid reimbursement from any Medicaid-eligible resident who was living in the facility on the date of withdrawal.
- These requirements should be clearly stated in the facility's contract with the state Medicaid agency and in its admissions contract with residents.

Current Federal Requirements: CMS currently has essentially no resident protections when an assisted living facility withdraws from Medicaid. For example, the HCBS waiver application submitted by states does not set any requirements for how states or facilities must treat residents when an assisted living facility withdraws from Medicaid.

By contrast, federal law specifically protects nursing facility residents from eviction when a facility decertifies. The issue arose in 1998, when a Florida nursing facility chain withdrew from the Medicaid program and then attempted to evict dozens of Medicaid-eligible residents. The resultant furor led Congress to amend the Nursing Home Reform Law to prohibit such evictions.[17]

Under federal nursing facility law, if a nursing facility is Medicaid-certified when a particular resident is admitted, Medicaid reimbursement in the facility always is an option for that resident, whenever her finances qualify her for Medicaid coverage. A withdrawing facility's Medicaid certification continues for residents present in the facility at the time withdrawal is requested, and does not end completely until all those residents have left the facility. This is true even with respect to those residents who enter as private-pay residents and become Medicaid-eligible only after the facility has taken steps to withdraw from the Medicaid program.[18]

State Practice: State laws typically require only that current assisted living residents be given adequate notice of a facility's withdrawal from Medicaid, with no substantive protections. *Illinois*, for example, requires that an assisted living facility notify the state 90 days in advance when surrendering its Medicaid certification. The facility must then give residents a 30-day notice of .....

17 Pub. L. No. 106-4, 113 Stat. 7 (1999); *see* Robert Pear, Bill Protecting Medicaid Patients Is Signed, N.Y. Times, Mar. 26, 1999, at A16.

18 42 U.S.C. § 1396r(c)(2)(F)(i)(I), (II), (iii).

involuntary discharge.[19] Under *Texas* law, similarly, a facility's withdrawal from Medicaid is an authorized reason for involuntary transfer or discharge.[20]

Problems akin to the 1998 Florida nursing facility scenario have arisen in assisted living facilities in several states. *Oregon* is one of the few states that have developed a response. The Oregon Medicaid program requires that assisted living facilities enter into "gradual withdrawal" contracts with the state that give residents protections that are comparable to those applicable in nursing facilities. The contracts protect residents already living in the facility on the date on which the contract becomes effective. The facility must accept Medicaid reimbursement on those residents' behalf, even if the particular resident becomes Medicaid-eligible after the initiation of the gradual withdrawal contract. The contracts generally are effective for only two years, but the state reports that most providers choose to renew them.[21]

In *Washington*, state law enacted in 2008 also gives residents additional security, requiring facilities post-withdrawal to accept Medicaid reimbursement from a resident who either 1) had received Medicaid reimbursement on the day before the facility's withdrawal, or 2) had paid the facility privately for at least two years and had become Medicaid-eligible within 180 days after the withdrawal.[22] The same law requires facilities post-withdrawal to notify both residents and potential residents of facility policy on Medicaid acceptance.[23]

Post-enactment, however, this law has been limited by a lawsuit by a provider association. A federal court concluded that the law unconstitutionally interfered with facilities' rights under their then current provider contracts, which allowed for withdrawal from Medicaid upon 30-day written notice by the facility to the Medicaid program.[24] As a result, the mandatory-acceptance-of-Medicaid provisions have not been applied to facilities with existing Medicaid provider contracts. Washington did not appeal the adverse court decision, but instead began revising its provider agreements to be consistent with the new law. Because Washington provider agreements run for two-year terms, full transition to agreements consistent with the new law should be relatively expeditious.

Going Forward: If an assisted living facility withdraws from the Medicaid program, the facility subsequently should be allowed—and required—to utilize Medicaid reimbursement on behalf of any Medicaid-eligible resident who lived in the facility at the time of withdrawal, even if the resident did not become Medicaid-eligible until after the withdrawal. This is the same rule that now applies to nursing facilities.

19 Ill. Admin. Code tit. 89, §§ 146.255, 146.285.
20 40 Tex. Admin. Code § 92.125(a)(3)(X)(iv).
21 Or. Dep't Hum. Servs., Div. of Seniors & People with Disabilities, Information Memorandum Transmittal, SPD-IM-08-018, Gradual Withdrawal Contracts for Assisted Living Concepts (Feb. 25, 2008); Gradual Withdrawal Contract List (2007), available at www.dhs.state.or.us/spd/tools/cm/facility_lists/grad_with_cont.pdf.
22 Wash. Rev. Code Ann. § 18.20.440(1), (3).
23 Wash. Rev. Code Ann. § 18.20.440(2), (6).
24 Washington Health Care Ass'n v. Arnold-Williams, 2009 WL 112673, 2009 U.S. Dist. LEXIS 2349 (W.D. Wash. 2009).

This rule is vital to the residents who depend upon Medicaid reimbursement, and who choose facilities based in significant part on Medicaid certification. Otherwise, residents are severely penalized, through no fault of their own, whenever their facility chooses to withdraw from the program.

For Information or Assistance: Contact NSCLC attorneys Eric Carlson, ecarlson@nsclc.org, or Gene Coffey, gcoffey@nsclc.org, or visit www.nsclc.org.

The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation and the education and counseling of local advocates, we seek to ensure the health and economic security of older adults with limited income and resources, and access to the courts for all.