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Free Webinar: Resident Rights in Medicaid-Funded Assisted Living and Group Homes

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Gelila Selassie: Hi everyone, this is Gelila Selassie. I'm a senior attorney at Justice in Aging, co-presenting with my colleague Eric Carlson, who's the director of long-term services and support also at Justice and Aging. And if you're here, it's for our webinar on Residents Rights and Medicaid Funded Assisted Living and Group Homes. Next slide, A quick synopsis about Justice in Aging. We are a national organization that uses the power of law to fight senior poverty by securing access to healthcare, economic security, and the courts for older adults with limited resources. We've been around since 1972, and we've primarily focused our efforts on older adults from marginalized backgrounds. Next slide.

Just a few housekeeping measures. Everyone is on mute. And if you have any questions, whether substantive or any technical issues, you can use the questions functions below. If you're having problems getting into the webinar, you can email trainings@justiceandaging.org. All of our materials from this training, including the slides, are available online in our resource library, as well as our past materials from past trainings. And a recording will be available on our Vimeo page at the end of this presentation. A closed captioning is available. And you can select that by selecting CC in the Zoom control panel. We also have a live ASL interpretation today as well. Next slide. And then if you want to receive more information or materials from us, you're welcome to join our LISTSERV by going to our website and hitting sign up, or sending an email to info@justiceandaging.org.

And we also have a very strong commitment to equity, and an advancing equity initiative. We recognize that the enduring harms of inequities are really profound for older adults from marginalized communities. And we recognize that in order to advance equity in all of our substantive areas of practice, that also requires us to recruit, support and retain a diverse staff and board across all demographics and communities. Next slide. Oh, perfect. And so for today's

webinar we have quite a lot of materials from our resource library that you're welcome to peruse. Two in particular that would be most helpful is one on defending evictions from Medicaid funded assisted living facilities, which is published last month. And then we also have a rights and wrongs and Medicaid funded assisted living that was just published this week. We encourage you to cite to those if you need any additional resources.

And so as we begin federal law, it seems unlikely that assisted living would have any federal protections. It seems very rooted in state law. Next slide. And that's true licensing standards are established by states for assisted living facilities. There's a ton of variation, and very little standards or uniformity across states when it comes to assisted living even in the name. So when we refer to assisted living, your state could be calling it a residential care facility or housing with services, or other name for it, but that's what we're referring to here. And so because of that it's really interesting to see that, "Well, wait, are there federal standards that advocates can utilize for their assisted living residents?" Next slide.

And then another way that assisted living can vary greatly between states is in how it's financed. Assisted living isn't a required benefit under federal Medicaid law in the same way that nursing home coverage is. States have to provide Medicaid funding for nursing homes, not necessarily for assisted living, so that's an optional benefit.

And it's usually covered through Medicaid home and community-based services or HCBS, particularly with the use of HCBS waivers. And these waivers can give states even more discretion or flexibilities in how they might administer Medicaid funding assisted living. And a crucial distinction is that Medicaid can only cover assisted living services. Room and board cannot be billed to Medicaid that's built separately. Oftentimes it could be through private payments, or if their state, or county offers any subsidy or grant to cover some of those housing costs. And we do recognize that because of the housing costs and assisted living, that can lead to some barriers for older adults. Next slide.

And so now we'll be getting into some of the federal protections. Next slide. So a quick overview of something called the settings, the HCBS settings rule, which was published in 2014. This rule is incredibly massive and incredibly technical. But at its core the goal of the rule is to make sure that settings that accept HCBS dollars are not actually institutional. Very often when we think of HCBS, you can think of the home care portion of it that people are receiving services in their home. But there are a lot of community-based settings like assisted living in group homes where individuals are supposed to be receiving HCBS, but it actually feels pretty institutionalized. If those settings aren't giving the individuals autonomy, or privacy, or some of these other expectations that we have when we're living in our own homes. And so the rule establishes several minimum standards and procedures to ensure that those settings are truly non-institutional. Next slide.

And so one question is if this rule was published in 2014, why are we discussing it now? Well, the deadline for implementation kept being delayed, and the final deadline for states to be coming into compliance was March of 2023, just this past year. So even though the rule is older, implementation and compliance with the rule is relatively recent, and during this nine-year period, states were developing CMS approved statewide transition plans to detail how they would ensure settings under this rule would be in compliance. And although the deadline for implementation was March of this year, CMS House allowed certain specific exceptions to states to become in compliance. And these extensions are called corrective action plans or CAPS. Many of these extensions we should note, are related to some of the pandemic era challenges, particularly staffing shortages. And we'll discuss this again later on. But one really important note is that CMS really heavily relies on advocates to bring some of these compliance issues to their attention.

These federal regulators are reviewing CAPS, they review these statewide transition plans, but there's only so much they can gain from that. And so it's really important that they know what's happening on the ground with the use of our advocates, which we'll touch on again later. And with that I will turn it to Eric.

Eric Carlson: Thanks, Gelila. Now we'll turn our attention to some specific legal protections with a focus on areas where facilities are likely to be violating these federal laws. So you see how these are set up. The wrong is what the facility may say, which is contrary to law. And then obviously on the other column the law what's right, what should be happening in these facilities. A central focus of the new federal regulations is that HCBS beneficiaries should not be segregated from the broader community, and this means that people's ability to get out into the community. You can note the broad language here, full access to the community. Facilities in a practical level at least initially are likely to offer minimal assistance, just a bare minimum, what we've got listed here. The bus schedules, some assistance making phone calls or whatnot. But residents should ask for more based on that full access requirement. This could require transportation, could require assistance. There are no precise listings of exactly what this might be because it's a flexible standard. So it's important that residents be prepared to ask for what they need individually in order to get full access.

Similarly, regarding schedules and activities, the language of the federal regulations, again, really broad. "A resident must have," you see the quoted language here, "must have the freedom and support to control their own schedule and activities." Note particularly the word support here. It's not enough for the facility to take a hands-off attitude as to what the resident does say, "You can do whatever you want to, we're not stopping you." But there's more of an affirmative obligation here, and the facility must go beyond that and provide the "support" that the resident needs. Again, there are dozens of ways in which this could play out. And again, the resident ideally is proactive, taking

the step and saying, "This is what I need. This is the freedom that I need in the support that I need in my individual situation to control my schedules and activities." Regarding staff access to room and privacy. Under the regulations staff cannot go in and out of residence rooms at staff discretion.

There's two legal protections that apply here. First, the entrance doors to the living units must be lockable with only appropriate staff having keys. And in addition there's a right of privacy, or just a broader right of privacy in the living unit. This means that staff I think as an implementation even with the key should always knock and ask for permission to enter, that honors privacy. So the key should only be used in what may be relatively rare instances, when for some reason the resident is unable to open the door, or to respond to a request for permission to enter. Regarding food, notably, a facility cannot limit food to just breakfast, lunch and dinner. You think of any of our lives, do I sometimes eat food outside of breakfast, lunch and dinner? Yeah, absolutely. And I would feel really put upon if I couldn't do that. Under the regulation the resident must have access to food at any time.

And the phrase any time certainly is clear, any has to mean any. Certainly, to give the facility some space here, they don't have to have a hot meal available around the clock, that's not what the regulation says. But likewise, a facility cannot skate by just putting a bowl of candy on the table for example. You think about the food that you and I and anybody might eat outside of meals. What is this? Coffee, juices, fruit, some sort of snack sandwiches, salads. Again, the specifics should be driven by the resident. What food does the resident want mid-afternoon or later at night, that's what should drive it. There could be some assessment of what's reasonable and what's not, but certainly that's what should drive it. And it's not unreasonable for facility to make this food available outside of the breakfast, lunch, and dinner time spaces. Regarding roommates, there may be practice in "institutional facilities," where the facility just drives it.

Facilities moving people back and forth and putting particular folks together, that's an institutional environment. The federal law that we're talking about here says that residents have a choice of roommate. Based on that regulation then roommates are not "assigned" by the facility. Instead, there has to be a conversation with residents to figure out who will be rooming with whom. It's not quite clear what would happen if there were some an impasse, but the basic principle is there needs to be conversation. It's not unilateral, and I obviously said this multiple times. The key is the resident speaking up and saying, "This is what I want." And the facility engaging with the resident in figuring out how to make things work. Regarding visitation this is fairly straightforward. Facility shouldn't be having "visiting hours" for limitation of visitation just in those times, that's institutional. And under the federal regulations, a resident can accept a visitor at any time of the day or night.

It'd be reasonable for a facility to have some rules about implementation regarding late night visits, for example. If a resident with a roommate were

accepting a visitor late at night, it would make sense obviously that that visit would take place in some location and facility that doesn't inconvenience the roommate. Decorating and furnishing a living unit. The facility cannot have a rule that prohibits a resident from hanging pictures on the walls, for example, or bringing in furniture, or mementos. For the room to not be institutional, it should feel like the resident's room. In general the resident should have a right to furnish and decorate the living unit the same way that the resident would furnish or decorate a room in a non-institutional setting in a private home or an apartment. Transfer within the facility.

What's wrong here as you'll see on the slide, is this institutional practice where a facility says for whatever reason, "You resident need to move from room five to room 11." That's not consistent with the federal regulations. The resident under the regulations, you see the language here rents a specific physical place just like a tenant might rent a specific apartment. And if you have an apartment, the landlord doesn't just show up one day and say, "Well, I want you to go from 201 to 305." You have a right to that specific apartment, that's what you rented. Same thing is true here under the federal regulation, and the control and stability that the resident gets is part of what makes the arrangement feel more homelike. Relating to eviction, a little bit more complicated here, so we won't be able to cover this in one slide. We're talking more about a half dozen slides because there are some permutations.

The basic right here, what's wrong is the facility just saying, "Get out. You have no right to appeal. It's unilaterally under our control. You need to leave." That's wrong. You can't do that under landlord tenant law generally in the state. And you shouldn't be able to do it in a setting here, whether it be assisted living or group home. Maybe we should stop and emphasize here that all of this presentation pertains to any HCBS reimbursed facility.

And sometimes those facilities are primarily occupied by older folks, and sometimes they're occupied by younger adults with disabilities. But the discussion here, we probably use assisted living as a shorthand to refer to that kind of facility. But the law we discuss here in the discussion applies to all those types of licensed facilities regardless of whether the resident is 80 years old or 25 years old. So just to make that point and then return to the eviction discussion. The right here ensures that a facility resident has at least the eviction protections provided by the state landlord tenant law. You should be doing at least as well as an apartment tenant in that state. Either the residents are explicitly covered by the landlord tenant law, or they have comparable rights established by the admission agreement.

Our issue brief on the eviction protections, Gelila mentioned that five 10 minutes ago, covers these various permutations in more detail. Give you a slightly shorter version here. That shorter version is that a state can comply with this requirement with this federal regulation in four basic ways. Most simply, the facilities are covered by landlord tenant law. A variation on that is that the

facilities are covered by landlord tenant law, but those landlord tenant protections are supplemented by facility specific regulations. These would generally be, for an example, a situation where the landlord tenant law gives you a right to a court trial to contest eviction. And the assisted living regulations supplement that by establishing only certain reasons for eviction from the licensed facility, whether it be in an assisted living facility or a group home or something else. So those are the two variations that involved the state landlord tenant law explicitly applying to those facilities.

Then the other two involve the written agreement. So assume in this state, the landlord tenant law doesn't apply. And so it is required then that there be a written agreement that give the resident at least the protections that he or she would've had under the landlord tenant law. And that could be done either by the state developing a template agreement saying, "Here's an agreement, everyone across the state has to use it." Or alternatively the state just saying everybody needs these agreements, and we're going to leave it to the facilities to devise and use agreements that comply with the law, and that provide residents with at least the level of protection that they would have under landlord tenant law. And let me just slow down and make one additional point here because I think I neglected to make it earlier. When we talk about landlord tenant law, usually we're talking about state law.

That's the most obviously common and most extensive law that's going to be involved. But the federal regulation explicitly also calls out landlord tenant law of other jurisdiction. So if for example, there is a city ordinance or a county ordinance that applies to the landlord tenant situation, that also has to be taken into account. And we'll discuss the situation in a couple minutes, where in fact that was carried out in a trial in an eviction proceeding held earlier this year in California. So those are the four ways that you can get compliance, either landlord tenant law applies. Number two, the landlord tenant law applies and it's supplemented by the assisted living or residential care facility regulations. Number three, the state develops a template agreement that establishes comparable protections. Or four, the state requires that facilities use agreements that establish comparable protections, but the specifics of those agreements are left to the facilities.

Then mentioned one other common approach, which would be the administrative appeals. Many states provided administrative hearing process for evictions from assisted living and group homes and similar facilities. I'd have to say this technically is non-compliant with the federal regulation. And we just talked about it has to be given the same protection as landlord tenant law. It's arguably non-compliant since the landlord tenant law is not applying, and the landlord tenant protections are not being established through the admission agreements. But the administrative hearing process generally will be considered a good outcome, and in most cases it probably complies with at least the spirit of the regulations if not the exact letter. The bottom line is it the resident gets a venue in which to adjudicate the dispute? And I'll have to say on a practical level

it may be a more accessible venue than for example a court trial in the local landlord tenant court. So just mention that it's going to be a common process that states are going to cite.

I think I would note that there's probably technical non-compliance here. But also recognize that the providers and state officials and resident advocate, other stakeholders may consider it a good outcome for the reasons that I just discussed, because it does provide a venue for these disputes to be adjudicated in.

Let's briefly discuss the practicalities of eviction defense. Many residents upon being threatened with eviction, just move out ASAP in a bit of a panic. "I got to go. If they don't want me, I don't want them." And it's driven a little bit I think about the fear of the unknown. And also by the fact that of course they're being evicted by the same facility that's in their face that's providing care to them 24/7.

So I don't want to denigrate people's reactions. It's understandable under the circumstances, but it is suboptimal. It's not the way to win a case. If you pick up and move, you automatically lose, and you can't come back later. I can't tell you how many times I've gotten... more when I did direct services, you get phone calls from people and say, "I pick up and left, but now I changed their mind, and I want to challenge it."

And my advice to them generally was, "Well, sorry about that. But the time to appeal was when you were there and after you "voluntarily" leave, it is difficult or impossible for you to revisit the merits of that potential eviction case. So because of that I would recommend to lawyers and paralegals and other advocates that they counsel the residents, it's better to take a deep breath and consider your options and make an informed choice.

The resident shouldn't be afraid to utilize the various appeal mechanisms that we've discussed, whether it be a court trial, something comparable established by the admission agreement, or administrative hearing. The advocate I think can honestly tell the resident that residents often win these cases that a facility may back down because it may not be willing to pay an attorney for a court trial. And the residents who win, generally get treated better going forward since the facility knows that they will stand up for themselves. And then before we move on from this topic, I want to point out the possible extras here. The specifics may vary from state to state of course, because we're talking about state landlord tenant law. Because the resident is entitled to at least the protection of landlord tenant law, there are areas in which the facility resident may get more than the resident would get under standard facility procedures.

This could be state law or as I mentioned it could also be a county or city ordinance. This is that example from a recent case in California, the state assisted living regulations provides for a 30-day eviction notice. But there's a

county ordinance, county landlord tenant ordinance that mandates a 60-day notice requirement if the tenant has lived in the residence for at least a year. So the facility gave 30 days, and then the resident in his or her defense made a motion for the case to be dismissed. Saying that this case is improper on it's face essentially, because there should have been a 60-day notice and this facility instead gave a 30-day notice. And the court ruled in favor of the resident dismissed the case. So that's one example of how these protections can be utilized. And as always I'm encouraging people to be aggressive and imaginative, and these are not wild theories at all.

The federal regulation says that you have to get a lease, the protection that the tenant would get under state or local law, local landlord tenant law, and that's nothing more than what this resident asked for in that particular situation. I'm going to briefly cover two states, Wisconsin and Nevada. The point here is that advocates should not necessarily assume that a state is in compliance, and I think Gelila will talk about some related issues in a couple minutes.

So the big picture message is if something doesn't make sense, don't necessarily assume that you are misunderstanding something. The problem may be with the state rather than with you. Even though Gelila said as she pointed out, there's been almost a nine-year implementation process because of the various delays. And you think after nine years everything would be just rock solid and compliant, not necessarily true at all. So again, if something doesn't make sense do not assume that you're misunderstanding it. It may just be that there is a lack of compliance, and there is still not just individual advocacy to be done, but systemic advocacy to be done.

And again, not just to make sure that facilities are honoring the law, but making sure that states are honoring the law as well. So briefly, in Wisconsin, the state transition plan for community-based residential facilities found compliance because the state regulations require written agreements, and the agreements must include reasons for eviction and notice requirements. But you notice what's missing there. What about your appeal rights? What are the protections for residents? You can notice a disparity between the CBRF procedures and landlord tenant procedures. The CBRF resident just has a right to request review by the state and not a hearing, not a trial, just send into the state and say make a decision. Whereas if you're a tenant in an apartment, you get a court trial and everything that comes with that. Do some discovery, some cross-examination, witness testimony, a right to appeal, all those things. But not a similar or equivalent at all to what the CBRF resident is getting by requesting review by the state.

And then you can also look at Nevada. The transition plan states that landlord tenant law applies, but actually the law excludes any facility providing a medical or geriatric service. And there's a problem there, the residents aren't necessarily protected under state law. There was a bill this year in Nevada to implement the new federal regulations. The original draft of this legislation included a right to

an administrative hearing to contest eviction, but those sections were deleted before the bill was finalized. Near as I can say, tell and I talked to some folks in Nevada, those folks don't necessarily have a good mechanism for appeal right now, contrary to what the transition plan said and contrary to the fact that of course the transition plan has been approved. So with that, I'm going to turn the microphone back to Gelila for discussion of a Medicaid related eviction issue.

Gelila Selassie: Thank you, Eric. If we can move to the next slide. So Eric has done a very thorough job on explaining some of the eviction protections available under federal law, or excuse me under state law based on some of these federal protections. But now we're going to pivot a little bit to look at what happens when a facility isn't trying to evict the resident right away, but there are Medicaid problems that occur that could lead to an eviction next slide. And so the way these situations could play out is where a resident is accepted into the facility and then at some point, and they're approved for Medicaid to cover their assisted living services. Well, even though the facility accepts Medicaid, they may claim to refuse the resident's Medicaid saying that the resident has to pay privately for a certain amount of time, say you have to private pay for 18 months and then we'll accept your Medicaid.

And the facility might want to do this because Medicaid reimbursements are relatively low, are pretty low so they want those higher payments that come with a private pay, private reimbursements. And so even though a facility may want to do this, it's wrong. By law provider or providers that is certified to accept Medicaid has to accept those Medicaid payments subject plus any associated out of pocket costs like a co-payments. And then they must treat those Medicaid payments as payment in full. The Medicaid certified facility can't just impose additional obligations because they want these higher payments from the resident. Next slide.

And so as we've said many times the number one rule is to not leave the facility even if the facility is completely in the wrong, it is incredibly difficult to try to get the resident back in even if the law is on their side, if they've already left the facility. And in a situation like this, the facility may try to claim that they can evict for nonpayment since they're requiring this private payment, which presumably the resident isn't paying. But a reminder is that since federal law requires Medicaid certified facilities to accept Medicaid, it's actually the facility that's not allowing payment to go through by refusing these Medicaid payments. And so that's how that can be flipped around from the resident's obligation to the facility's wrongdoing for instigating that non-payment. Next slide.

As is often the case in these areas of law, there's always a bit of caveats and complications. And one is that your state law may implicitly allow for duration of stay agreements. Like that example we just gave where the contract requires the resident to pay privately for a certain amount of time as a prerequisite to the facility accepting Medicaid. And so there's a couple of state examples of

this. For one in Minnesota the law requires assisted living contracts to include any limitations on the number of Medicaid residents at one time or if there are any duration of state agreements. In New Jersey they're required to provide this disclosure handout to residents, which includes if the facility expects the resident to pay privately for a certain number of years before accepting the resident, which is a duration of stay agreement.

And so even though the state law isn't expressly saying, "Oh, facilities can allow these agreements to take place." By requiring the disclosure of them, they're effectively saying it is okay to have these agreements as long as it's disclosed to the residents, which is contradictory to this earlier citation that we had that says a Medicaid facility has to accept Medicaid as payment in full. And so in situations like this, it would be appropriate to instigate some sort of advocacy like litigation against the state to show that this policy violates disclosure of duration of stay agreements can violate federal law.

Next slide. Another really common situation is where the facility denies the Medicaid payments from an existing resident because the resident isn't in a Medicaid designated room or Medicaid certified room. And just like with the previous example, the law requires facilities that take Medicaid to accept Medicaid as payment in full. Additionally, the facility may not actually have those rooms designated as a Medicaid room. So there's some additional considerations there. Next slide. As I mentioned facilities could just be kind of arbitrarily as assigning or designating the room as a Medicaid room, but there's no real weight behind it or no real meaning behind that. It's just something that they've said. And so because the resident isn't in that, they can say the resident isn't in the proper room that we bestowed as the Medicaid room, and now the resident must pay us privately. In that situation the resident could just say, "Nope, I am staying in this room and you have to accept the Medicaid payment just like in that first example."

But in this situation, the facility could actually have some weight behind their designations if the facility is designated as a partial certification facility, which means that some rooms are certified for Medicaid. And this is a practice that some states allow. And so to counter this, residents should research if their state actually does allow the partial certification, that their facility is actually designated as a Medicaid partially certified facility. And that even if both those things are true, that state allows these partial room certifications, and that the facility is designated as such. Advocates and residents could do a little bit more research to see if they can challenge the way the state went about and issuing those designations. So when states are providing their HCBS services, they typically do so through a waiver. And some of these things like whether there's a designation on how facilities can accept Medicaid recipients should be included in the waiver. And there should be a process in place for people to have opportunity to comment and to review and if that was actually approved by the federal regulators.

And so that's another way to challenge a situation there if it looks like your state does allow this process. And then another situation could be that the resident could just request a transfer into a Medicaid room. And so now we're going to go into some advocacy strategies that are a bit broader than just the eviction protections. Next slide.

As we discussed, HCBS beneficiary should have opportunity to appeal adverse decisions, or any grievances that are contradictory to the care that they need. But it's really often difficult for residents to know what the process is for filing appeals or grievances. So it's really important that advocates share whatever their state process, or procedures are based on what their approved plans under the settings rule. The CMS approved final plans under the settings rule should list something, as well as maybe in subregulatory guidance or other policies that the state may have should list those out. And it's really important that that is shared widely, so individuals know what their rights are and what their options are. Relatedly establishing a formal or informal referral system, so that residents in these situations can get help quickly is useful. As well as just providing a system of sharing information with advocates who are in this practice.

So that could be your state's protection and advocacy team, local legal advocates, ombudsman, another aging advocates as well. That way everyone's sort of on the same page as to what the process is if a resident is experiencing something that needs to be appealed or to file a grievance. Another tip is that when helping residents with their grievance or appeals, you should look at the individual's person-centered service plans as proof that the facility is not meeting their obligations, or that the facilities in non-compliance. Service plans are completed with the resident when they're approved for HCBS. And it specifies and details everything that the provider must do to meet their resident's needs. So that establishes a really useful standard to say, "Hey, facility, you are in non-compliance and here's the proof by this service plan, but all parties were a part of when it was being developed."

And then lastly, again, the big reminder of residents rights, particularly in eviction cases and that they really should stay put and fight the eviction rather than leaving. Next slide. In addition to that individual advocacy to help residents, there's a lot advocates can do systemically with the state to fix problems on a wider level, or even to prevent them.

So for one states may still be submitting their corrective action plans that detail how they will continue to becoming in compliance with the settings rules. And these plans are subject to notice and comments. So advocates could always provide comments on some of the things they'd like to see as part of these CAPS.

And then another really useful strategy, and it's a little bit easygoing, a little more informal, but just more basic, simple informal advocacy with state officials

can be very useful. A lot of state advocates are already doing this now, where they're holding regular calls with their state Medicaid officials, and county Medicaid officials and so on, to discuss how this implementation phase is going.

And discussing what compliance measures are available. And so that can be very mutually beneficial. Advocacy doesn't have to be particularly adversarial or particularly formal. It's kind of in everybody's interest to resolve some of these issues if facilities aren't meeting their obligations quickly. And so appeal processes and litigation, they can be time consuming, they can be costly for all parties. And so that's another strategy to go about to try to resolve this. Again, implementation of this rule is in its infancy, there's pretty meaningful opportunity to engage in that informal advocacy.

And also this process really shouldn't be static. As I said, everything is relatively new. Something might be established in your state, and it's more than appropriate for advocates, and stakeholders, and officials to go back in and say, "Hey, there are more areas of improvement, even though we do have this appeal process in place or this grievance process in place." There's always opportunity to continue this work and improve on it even if you do have something established. Next slide.

And then lastly, as I said earlier, CMS really needs input from local advocates and hearing what's on the ground. These protections are new and CMSs mechanisms for enforcements are not well established. And so even just recently is when federal regulators have started looking at this issue around evictions and enforcing individual rights. So we definitely need a lot of support there. And so we do want to hear from you.

You're welcome to reach out to us if you're seeing non-compliance issues in your state, and we'll do our best to elevate those issues to CMS. We do have this caveat that we can't guarantee any quick fix. Again, this process is so new and a little bit of the cart leading the horse at times. But even if there isn't a quick fix to that one specific issue, the hope is that by raising some of these problems that we're seeing across states, it'll allow CMS to create a mechanism that provides a more systemic resolution. And with that I will pass it back over to Eric.

Eric Carlson: Thanks, Gelila. The final topic is just for a couple minutes is a bit different. Up until now we've been discussing advocacy based on residents legal rights and their dealings with the residential facility. We're going to conclude here with a discussion of state Medicaid policies, because it's an important topic for residents and an opportunity for some impactful state level advocacy. So if you're assuming obviously anyone who's listening to this webinar is interested in HCBS residential facilities and the rights and lives of residents in those facilities, this Medicaid topic is entirely relevant and important to that population.

So briefly, Medicaid generally allows for coverage to begin up to three months prior to the application month. And the most important thing is not even three months prior, but at least right when the person starts receiving services, even if they just apply then. So if a person moves into a nursing facility, for example, Medicaid will cover beginning on that very first day assuming that the person is found to be eligible.

So you move in, maybe the Medicaid determination isn't finalized until months later, but Medicaid pays back up to that first day. But that's not how it plays out for home and community-based services in a home or in a residential HCBS facilities. If a person begins receiving home and community-based services, coverage won't begin until sometime later when a service plan is formally approved.

And that's a problem. And so because of that providers aren't willing to provide care upfront because they won't get reimbursed. But let's assume I need care right now. I can go into a nursing facility today. Nursing facility is going to get covered starting from today. And because of that I can afford it even though I am being eligible for Medicaid. Not so for home community-based services for me, because if I want to get home community-based services today, I'm not going to be able to get that reimbursed back to today.

Maybe it would be able to get started. This varies from the state to state one, two, three, four weeks later, depending on the process for getting a service plan finalized, or maybe some other administrative delays as well. I'm eligible for Medicaid, I don't have any extra money, and the HCBS provider isn't going to be willing to go out of pocket to provide services that aren't going to be reimbursed. So it's more likely that I'm going to go to a nursing facility and that's not the best option for me. It's not the best option for the state either, because it's probably going to end up being more expensive. So the underlying problem is the state requirements, excuse me, federal requirement, CMS requirement that HCBS coverage cannot begin until the service plan. A formal full service plan has been finalized and approved. There's a potential state strategy to address that problem. It actually dates back over 20 years in a Olmsted letter, a guidance to state Medicaid directors that authorizes these provisional written plan of caress, that identifies the essential Medicaid services and would be effective for up to 60 days.

And if that were the case using me as an example, again, if I were to start getting HCBS today based on a provisional service plan, something bare bones that was put together on the spot to at least get things moving, then maybe I would be able to access home community-based services because I would go under provisional service plan. The provider would understand that the provider would eventually be reimbursed, maybe my formal written service plan. As Gelila mentioned this is a more significant document that involves some interdisciplinary conversation between the resident, the resident's representative, and various professionals involved, let's say that gets approved

and finalized several weeks from now. Everything's good because everything gets covered, and I was able to move into home community-based services rather being forced to move to a nursing facility.

The impact here is fairly obvious. It's exactly what happened to my hypothetical situation, applies to other people in that situation, and they may end up going into nursing facilities unnecessarily. So I'll have to say this all seems very positive. I've looked at the Olmsted letter. The intent is clear. The intent is to address this problem that we're discussing here. It is unclear whether any state is utilizing these provisional service plans. So please let us know if your state is using these provisional service plans, or feel free to let us know if you're interested in advocating for their use in the future. It seems like an extremely useful and important thing to address this problem, and we're willing and eager to help because the benefits seem clear. So with that, I can see that we've gotten a few dozen questions during the session here. I'll turn control back over to Gelila, and we'll address the questions as best we can.

Gelila Selassie: Thanks Eric and I figure maybe we can sort of just go back and forth on some of the questions. One question for you, Eric, there's a couple of foundational questions about when do these rules apply? So one question was that they apply to dementia care assisted living facilities, or if they apply to assisted living facilities that are only private pay.

Eric Carlson: This is predicated on being able to be reimbursed through Medicaid. It's only for facilities that accept Medicaid, home community-based services reimbursement. So if a facility doesn't accept home community-based services reimbursement, then the federal regulations don't apply. Regarding dementia care that shouldn't matter.

Yes, if a facility calls itself a dementia care facility or calls itself a memory care facility or whatever, that is not determinative. Like Gelila said towards the front part of this presentation, there's a lot of names that facilities use in states use. States have various classifications and then even if states have classifications, facilities may just call themselves something else for marketing purposes.

That's a lot of the memory care and a lot of these situations, there's no state licensure category for memory care. It's just that facilities have found that from a marketing perspective to be a more effective way to characterize what they do. So the short answer is that the memory care it's probably subject to these rules. The thing that you have to figure out is which type of care can be reimbursed through Medicaid home and community-based services in your state. And then secondly, whether the particular facility you are dealing with is a facility that is certified to accept that HCBS reimbursement.

Gelila Selassie: Thanks Eric. And then there was another couple of questions related to what eviction protections are there. If assisted living is private pay only or not taking Medicaid, or what other protections are available. And my understanding there

is just sort of depends on what the state offers. It doesn't seem like outside of federal Medicaid protections, there aren't any standards or regulations for facilities that aren't taking Medicaid on a national level.

Eric Carlson: It's hard for us to generalize because it's going to be a question of state law. So if we're talking about facilities essentially the federal law doesn't apply, they don't accept Medicaid. And so we're just talking about assisted living or group home or adult residential facility, whatever it is. It's a question of state law. Just the general advice I think we can give is it, again, rule number one applies. That don't panic, even if the protections of the state may be a bit nebulous, it oftentimes is worth staying and arguing that you do have a right under the landlord tenant law.

Again, there's a lot of variations from state to state, but usually the state law will talk about this state law, landlord tenant law applying to any dwelling unit or a similar term. And unless there's a provision that explicitly excludes these facilities from the definition of dwelling unit or housing or whatever it is, then there may well be a reasonably solid argument that the person in minimum should get the landlord tenant law.

And I think on a practical level, it's a reasonably appealing argument because if you end up in front of a judge, the provider has to say, "These people have no protections whatsoever. We couldn't do this to an apartment tenant, but we can do this to this 85-year-old woman. We can throw her out anytime we feel like it and nobody can stop us." And that's just not an incredibly appealing argument. And so if there's at least a semblance of a legal argument, it's possible that a judge will be reasonably sympathetic towards the argument that there's some protections for facility residents.

Gelila Selassie: That's really helpful. There was a couple other questions related to what we discussed at the end, regarding where people can turn to ensure that these HCVS protections are being enforced. And I think a side just to reiterate, all of this is still very new. And so local legal aid advocates, protection and advocacy groups, potentially ombudsmen are definitely a good place to start, as well as potentially the state assisted living licensing unit, or the state Medicaid office as well. I don't know if you had any other thoughts there, Eric?

Eric Carlson: Those are all good ideas. I think I'll just maybe reinforce what you said about this being new. And it's not just that it's new, but that it is putting obligations on state agencies that haven't done stuff like this before. The state Medicaid agency and administering their home community-based services waiver probably hasn't been involved at all with what those facilities have been doing. And probably hasn't been expected at all to take any complaints or concerns from beneficiaries. It's just been a matter of a determining whether people are eligible or not, and then cutting checks to the providers without really being involved much at all with the kind of care that's provided. So there's definitely a

learning curve. There's a need for an infrastructure regarding monitoring, and assistance, and enforcement that hasn't existed, and may still not exist.

So it's going to take some time, talk to those people I think. If we can be helpful in working through some of these things, let us know. We do talk to CMS, not that they necessarily immediately do what we ask them to do, but there's a need for conversation and coordination. This is definitely a work in progress.

Gelila Selassie: Yeah, agree on that. Please feel free to reach out to us. I know we're at the top of the hour, so if you have any other questions or anything to share with us, our emails are there. The recordings and the slides are available on our website as well, but I think that is it. Thanks everyone and thank you Eric. Thanks to our ASL interpreters as well. Take care.