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## Who's Monitoring Medicaid Assisted Living – A Brief Overview

Webinar Transcript

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Eric Carlson:

Welcome to today's webinar. I'm Eric Carlson. We're going to talk about monitoring of Medicaid assisted living. This is presented by us at Justice in Aging. We're a national nonprofit that focus on benefiting, protecting older Americans, particularly those who have been historically disadvantaged and who have limited financial means. I think we can keep the housekeeping brief. I'm sure everyone has used Zoom before at this point. There's no functional chat today, but what we've got is the questions button. So use the questions button for logistical questions and for substantive questions, and I will address the substantive questions at the end of today's presentation.

We put out at Justice in Aging, lots of resources focused on health advocacy and income advocacy and other topics. You can access those resources by sending an email to [info@justiceinaging.org](mailto:info@justiceinaging.org), or if you go to our homepage, just look at a button in the upper left-hand corner that says sign up. We have a focus on equity here at Justice in Aging that extends both to our substantive advocacy work and also to our internal practices with staff and board members.

So turning to the assisted living topic more specifically, there's three guides that we recently put out that you may want to take a look at. They're listed here and the links are going to be posted in the chat as well, I believe. Rights and Wrong in Medicaid-Funded Assisted Living, which talks about the relatively recent federal rights established by the HCBS settings regulation. Then secondly, a more detailed guide focusing on a particular, one of those federal regulations, the eviction regulation, which goes into significant detail about how to advocate and how to think about what your state may or may not have done to implement these protections. And then finally, a document from the last couple months that focuses on the quality measures that were used in assisted living waivers, and we'll adjust that a little bit here, but that document's available as well. There's the larger document and then there's also a shorter document that's a little bit of a summary that's maybe a little bit of a jumping off point

before you get into the more detailed document talking about the performance measures.

So with that as an intro, we'll start on talking about the subject for today, the basics. Well, what is the monitoring here? Is there a federal law? There's some really important threshold questions that it's important to understand right at the beginning. First of all, there is no assisted living benefit in Medicaid as opposed to, Medicaid has some specified benefits. We're familiar with them. There's some mandatory services, hospital services, nursing facility care, physician services. You look in the Medicaid law, they're listed there. And if you have a state Medicaid program, your state Medicaid program has to offer all of these benefits, and then there's some optional services as well. It's a state option. Dental care is an example, and Home Community-Based Services as well. The federal law sets up some standards for them but doesn't require them. It's a state option whether and how to accept and implement those optional services.

So if you look at the Medicaid law, looking for assisted living, right, if you pull up the federal statute and search for assisted living, you won't find it and you won't find it in the federal regulations either. So how does Medicaid cover this if there's no assisted living benefit? It is covered generally as a Home Community-Based Service, so this is the same kind of benefit that maybe most commonly is used to provide services in the home. A lot of HCBS benefit programs provide personal care services and other kinds of services as well. Home modifications, for example, home delivered meal, adult daycare, those are all examples of a Home Community-Based Service and listed here are some of the most common mechanisms used within Medicaid to provide for these Home Community-Based Services, Home Community-Based Services waiver, Medicaid demonstration waivers. The demonstration waivers can be really broad, but one of the many things that they can do is provide Home Community-Based services. There's their community first choice option.

All these are mechanisms to provide Home and Community-Based Services, and in general, the fair amount of flexibility given to the state among the flexibility is the state option, the ability to limit enrollment, so. Limited enrollment, these are the kind of programs that might have an enrollment cap, for example, and then a wait list stemming from that. One other mechanism is the personal care service. This is an optional benefit under Medicaid as opposed to a waiver benefit, but again, it's the type of service is similar to personal care services. These are things that can be provided in somebody's home or in some states it's a state option, can be provided in an assisted living facility or other type of residential facility because they're not a waiver program. When it's provided through this mechanism, there cannot be an enrollment cap. There could not be a wait list. So because of that, not saying this is a good thing certainly, but because of that, you see this option taken up by a relatively small number of states. The most common mechanism is the Home and Community-Based Services waiver.

So those are the ways in which it can be funded and provided, but how is it provided? How is it defined? What are the standards? The presentation today is going to focus on the Home Community-Based Services waiver because that's where most of the substance is. This would be a very short program if I were talking about the substantive standards provided under the demonstration waiver because there essentially are none. It's a demonstration waiver, it's experimental waivers. A state has incredible amount of flexibility, but there's a significant amount of structure in the Home Community-Based Service waiver regulations and guidance, which gives us ability to talk a little bit in specifics here. The technical guide for the Home and Community-Based Services waiver, long document, a couple hundred pages long or close to that. Provides a definition for assisted living, as you'll see here, includes personal care supportive services, 24 hour onsite response capability to meet the resident's needs.

And it may also include, again, this is from the same document, nursing and therapy services, which are listed as incidental and also such things as medication administration, transportation, et cetera. Again, this is a benefit and in the same guide that talks about other Home Community-Based services benefits, like some of the things I mentioned before, the home delivered meals or the home modifications and whatnot. But so Home Community-Based Services waiver provides for a good number of potential benefits that a state may choose to provide under Home and Community-Based Services waiver. One of those is assisted living services. Note that for Home and Community-Based Services waiver, never will the waiver cover room and board. Medicaid generally doesn't do that with the exception of hospital care, nursing facility care. Home Community-Based Services doesn't. If you receive Home Community-Based Services at home, it'll provide for services and the other things I mentioned like the home modifications and whatnot, but won't pay your rent, won't pay your mortgage, won't pay your grocery bill.

Same thing is true if that Home Community-Based Services benefit is provided in an assisted living facility or in a similar, when we talk about assisted living, the name is going to vary from state to state, the regulatory name. Could be assisted living, could be residential care facility for the elderly, could be adult residential facility. There's a variety of names, but we're still talking about the same general thing. It's a non-nursing facility type of residential setting. So these are the definitions. Provide personal care, some other level of incidental services that may be more health related, but not room and board.

Let's move on and talk about quality then once we know the basics of the benefit. Again, focusing on the HCBS waiver standards, there are no particular quality standards. There's a definition, but there's nothing in the waiver document that says, for example, staff needs to have such and such level of training or there needs to be such and such presence of nurses or anything, or that care has to be provided in some specific way with some minor exceptions we'll talk about at the end. Instead, the state has to make six assurances as part

of the waiver application. And again, right, most of these waiver applications are for services provided at home, but it could also be for assisted living.

And so those six assurances are the six listed here, administrative authority, this programs running correctly, level of care, that the program's distinguishing properly as to who's qualified and who's not. I maybe should have mentioned earlier that one of the requirements for the waiver, the HCBS waiver is that the resident need the level of care that would otherwise be provided in a nursing facility. So the resident needs nursing facility care or the equivalent. That's a condition of eligibility under the benefit. So the terms level of care, moving back to the assurances, that the providers are qualified, the service plans are constructed appropriately, health and welfare is protected, and that financial accountability of the program is maintained. Look at the qualified provider's assurance. There's a little bit of detail underneath that. The state promises, just as you see here, basically that your minimal licensure type requirements are met. Right. The people who are providing the services are actually licensed to do so. It says that. The state monitors, if they're non-licensed people, the state supposedly is monitoring those folks and is verifying that the provider training is done correctly.

Most of these assurances of practical matter are based on the state having a licensing agency. So let's assume that this is an assisted living benefit, of course, and the Medicaid program, state Medicaid program is administering the waiver, but they're not licensing these facilities. They're instead making these assurance to the federal government, and those assurances are based upon the fact that the state has another agency, maybe another part of the, not the Medicaid agency, but maybe it's another division within the state health department, or it could be a separate agency entirely like Department of Social Services. Again, all the names are going to vary from state to state, but in most cases, the Medicaid agency is saying there's somebody else in the state. They've got the license for these places, they're probably doing a good job. Everything is fine. The state have it covered.

Then also looking at the health and welfare assurance, this is a little more idiosyncratic from where I sit. Again, this system is devised primarily for services provided in the home and the state promises to identify and address instances of abuse, neglect, exploitation, and unexplained death, that there's an instant management system that's going to do that kind of monitoring. The state follows its own policies on restraint and seclusion, which is actually a very limited protection given that it doesn't specify what the policies might be and that the state establishes and monitors overall healthcare standards. There's no particular standards because again, this is a waiver document. It could be talking about care provided at home, but instead we're talking about assisted living care in this case, and so the focus is on assurance, but without any particular specifics that the federal government is going to require.

There is some reporting done, so it's not solely assurances. So if the state's promising they're going to protect these things, and that does some reporting that purportedly gives the federal government some assurance that the standards are actually being maintained. There are these annual 372 reports to CMS. As part of the HCBS waiver process, these 372 reports, first of all have some numerical and financial information listed here to show that it's cost neutral essentially, and that the enrollment levels are being maintained appropriately. Number of participant, days of enrollment, average length of enrollment, and then all the expenditure info about expenditures per service and total expenditures.

And then there's also a portion of the 372 reports that reports on quality. It's not a lot of detail here if you look at it, but these assurances really are just assurances. It's more of a box checking thing. We affirm as the state that the provider standards and health and welfare standards were met and that the providers were trained and licensed certified. So if you look at the 372 reports, the total report is just, I believe three pages long. The numbers are significant, of course, because they're monitoring what's going on in the program. But again, from my perspective, at least our perspective, that the quality in information is relatively thin.

And then it goes on to state either that no deficiencies were detected or if there were detected, the state gives some summary of the areas where these deficiencies were detected and gives some explanation about how the problems have been corrected. As I'll acknowledged, I think multiple times during this presentation, there's a lot I don't know, a lot we don't know. I think a lot that people in general outside of the federal and state governments don't know because a lot of this information is not routinely posted and you've got to make public records requests in order to get it.

Most people haven't done that yet. So my sense is that this discussion of deficiencies is relatively pro forma, but the disclaimer there is, I've only been able to review a handful of these at some point. It's hardly a comprehensive review. Also, talking about the reports to the federal government beyond these 372 reports and that information, there's also these performance measures. It's part of the CMSs focus on continuous quality improvement. They talk a lot about this in CMS generally. And in the waivers, this concept is enshrined within the waiver application themselves. If we read each of these HCBS waivers, there's a template that the federal government has that states fill out and submit for the approval of the waiver. They tend to be 150, 200 pages long, and you've got to look through a lot of them to get a little comfort level to be able to understand what's going on.

To that I just say I think they're a little bit intimidating to start, but I encourage folks to take a look at them. Scattered throughout the document, there will be mention of these performance measures, which are meant as a strategy for continuous quality improvement. The state collects this performance measure

info. They're expressed as percentages. Out of this population, we'll talk about some specific quality measures in a second, but the denominator is the bigger population, and then the quality is measured by the numerator, the percentage of times in which some particular occurrence happened, and compliance for CMS is considered above 85%.

And then this info is provided to CMS during the lifetime of the waiver. The waivers tend to be renewed for five year periods, and then at least one year before the waiver expiration period CMS issues, a draft report to the state is based on the information that the state provides on these performance measures. Then the 85% level, which I mentioned the state either disputes the finding in the report saying we are actually in compliance for such and such reason or proposes a plan to remediate the problem. We the state acknowledge that our quality measure fell in the low 80s or the 70s percent, whatever it is, we recognize it's a problem and we propose to address that by doing X, Y, or Z.

We did relatively recently do some digging in. We're just starting the digging in process and we started in California with a Public Records Act request and got the performance measures for the California Assisted Living Waiver. This is the report that I mentioned earlier. The link is in the chat, encourage people to take a look at it. There are 18 performance measures. I would submit that only five of these had anything really to do about quality, and none of them were particularly useful, particularly these early ones. Again, the state showed almost across the board really high measures, 100% compliance, 99% compliance. But in part because measures just weren't very meaningful, that the licensure certification didn't lapse, that they maintained provider qualifications. They were qualified to provide services. They did mandatory in-service training. Well, that's like me saying, our law firm is great because all the lawyers pass the bar exam.

Well, that's fine, that's good, but that's not quality. That just means you're minimally qualified to do your job to begin with. So 100% of the doctors performing surgery at the hospital graduated from medical school. Again, that's great. I'm glad they graduated from medical school, but that doesn't demonstrate quality, and that's the problem with a lot of these measures here. They're guaranteed to give you 100 or high 90%, but they're not the sort of thing that legitimately measures quality. It's pro forma, it's paper compliance, however you want to describe it.

And then the last item here, to be fair, that could be a legitimate quality measure if there really were a process that determined whether services were delivered in accordance with a waiver service plan. That was dubious in this case, because the data is questionable in ways that are explained in the report in more detail, and then it's just, as I mentioned, some of the times 100% compliance is more questionable than 90 or 80 or 70. All the care coordination agencies were enrolled. You would hope so. All the level of care determinations were performed by a nurse. Well, that's a requirement. They have to be

provided by a nurse. And then this number is just so large, it's hard to take it seriously. Did the state somehow audit 20,236 level of care determinations and determined they were performed appropriately? I think that's dubious, and again, the 100% just raises some questions about how meaningful this review of quality is.

Also mentioned that we had difficulty getting this info. It wasn't posted, filed a Public Records Act request. The state didn't comply, and we ended up filing a lawsuit in order to get the information. And there was just no evidence in looking at this that these were really meaningful, that it screamed out that this was something that the state had to do to keep getting the federal money. And so there was some back and forth with the state of California and the federal government for writing these reports and generating these percentages. But again, from the outside, it's hard to believe that it was useful, that this information was done, used, implemented any meaningful way to actually make things better for program participants.

I 15, 20 minutes ago made a little bit of a disclaimer when I talked about the absence of federal standards. They're now, for the first time, is a little bit of federal regulation that affects federally funded assisted living, what's referred to as the HCBS Settings Rule. It was enacted 2014, but then there was a long, long, long transition process, and so states ultimately weren't required to come into compliance until 2013, excuse me, 2023. 2023. And then even with that, some states have permission to delay implementation a little bit longer due to some Covid related difficulties in staffing. But in general, the standards I'm going to talk about here are going to be in effect in each of the 50 states at this point. The Settings Rule comes from this idea that home community-based funded settings should be non-institutional. Home Community-Based Services were created to create an alternative to institutional care.

That's the whole idea. But the observation was, I think, accurately that yeah, some of the HCBS Settings were just overly institutional. The assisted living facilities maybe, some of the adult daycare centers, people were not out into the community. They really were segregated in these quote, unquote non-institutional settings. Sure felt institutional to a significant extent. So that's the philosophy behind these regulations to make sure that these HCBS funded settings are actually non-institutional and folks aren't segregated from the broader community. So there are some standards. These are covered in more detail in that Rights and Wrongs in Medicaid-Funded Assisted Living guide that was mentioned earlier. It includes some eviction protections, some privacy protections, a right to choice of roommates or right to accept visitors.

But I would submit that one of the potential problems is that there's no enforcement mechanism that you look in the state transition plans and some of the other federal guides, it is unclear how these rights are going to be implemented. It's like if a provider doesn't follow these rights, doesn't give a choice of roommate, for example, or tries to evict them properly, what's the

beneficiary supposed to do? To go to the Medicaid agency, to go to the licensing agency? If you look at the state systems, you'll oftentimes see some gaps there.

So the Medicaid program where these regulations purportedly sit, is set up to do these performance measures and quality reports and whatnot. But they're not necessarily set up to do the kind of monitoring that I'm talking about. The state licensing agency probably has more focus on taking complaints, but they may or may not have jurisdiction over these federal regulations. So I want to be clear, we at Justice in Aging realized that there's a tremendous amount of work to be done. That's one of the reasons why this session was limited. Was advertised as an overview, right? We want to give people a initial view into this, some initial thoughts. We recommend that you look at the state transition plans for the HCBS Settings Rule. The state there supposedly listed how it was going to be compliant with these federal standards. That's an important place to look. Also, take a look at the HCBS waiver application and the performance measures to see what the state is proposing and what it's requiring of the providers.

Really encourage people to dig into the data. I think a lot of times this information just isn't available, right? These 372 reports, the critical incident information, the performance measure information. Like we said, since we wanted to get the performance measure from California, we had to first file a Public Records Act request and then we had to file a lawsuit when they didn't comply. So I encourage, I think in most cases the lawsuit won't be necessary, but at a minimum, I could encourage people to, if these things seem completely unfamiliar, make those Public Records Act requests and see what you can find. And then in our resources, I think are a good start of this, publicize these federal requirements. People should be aware of these rights, and if their rights are being violated, they and the advocates on their behalf need to be poking at the state saying, "What are you going to do about it? Where should people comply? How can we get some remedies here when providers do the wrong thing?"

And speaking on my behalf individually, on behalf of Justice in Aging, we are very eager on working with you on this. So feel free to call us with any questions and to share any information. This is my email address and happy to or again, very eager to work with people and to dig into this and build out the advocacy in this area. So with that, I'll ask Hannah, my colleague to jump in here and we probably have time to maybe dress a question or two. And any questions that we want to take a look at Hannah?

Hannah Diamond: Yeah, Eric, there was just if you could remind the advocates, given all the complexity about trying to get access to the quality measures, if that really presents a burden for someone or is a barrier, how can advocates go about using maybe other levers to improve quality in their state? What else should they be thinking about?

Eric Carlson: Yeah. I would start with those HCBS Settings requirements. Those are regulations. Those are rights that exist right now. And I think that's a good

jumping off point to explore some of the unanswered questions here. We've got these federal regulations, but who is going to enforce them? Is it the Medicaid agency? Is the state licensing agency? What's the communication within the state to make these real? They've now purportedly complied, but how is that going to become real for the people living in assisted living and in other similarly state licensed facilities?

Hannah Diamond: Right. Eric, I think we are out of time, unfortunately, but I think we thank you for today's information and please reach out to Eric with additional questions or what you're seeing in your state. And we have recorded all of the questions that are in the chat, and we will follow up with you there as well. So thank you so much for joining us.