Testimony on Long-term Care Settings: Personal Care Homes and Assisted Living Facilities

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Good morning, Chairs Kinsey, Kim, Heffley and Mentzer, committee members, and staff. I am Juliet Marsala and I serve as the Deputy Secretary for the Office of Long-Term Living (OLTL) in the Department of Human Services (Department or DHS). I would like to thank you for the opportunity to testify today regarding long-term care settings, specifically Personal Care Homes (PCH) and Assisted Living Residences (ALR) and how the department considers both settings integral to the long-term care continuum.

Pennsylvania's long-term care system is a life-sustaining resource for the seniors and adults with disabilities who require daily care and support, and PCHs and ALRs are an important option for addressing the needs of this population. In many cases, these facilities serve adults on extremely limited incomes. I would like to provide an overview of each of the settings and the funding associated with each setting, so there is a better understanding of the unique differences and when home and community-based services can be provided.

Personal Care Homes

PCHs are designed to provide safe, humane, comfortable, and supportive residential settings for adults eighteen years or older who do not require the services in or of a licensed long-term care facility, but who do require assistance or supervision with activities of daily living (ADLs), instrumental activities of daily living (IADLs), or both. Adults who reside in PCHs may qualify for Medical Assistance, Medicare benefits, or Veterans benefits, including physical and behavioral health services.

PCHs serve four or more adults and provide assistance to develop and maintain maximum independence and support self-determination. Within a PCH no more than four residents can share a bedroom with 100 sq. feet per resident with mobility needs, 80 sq. feet for

single residents measured wall to wall, and 60 sq. feet for shared bedrooms. The PCH must have one flushing toilet and sink for each 6 residents and staff. In addition, there needs to be a shower/bath for every 10 or fewer users and a kitchen area for the home.

The PCH setting is licensed by DHS under the regulations at 55 Pa. Code Chapter 2600. Although the DHS has oversight of PCH licensing, this setting is not funded by Medicaid, with the one exception of residential habilitation services.

As of September 01, 2023, there were 1,054 licensed PCHs in Pennsylvania. Approximately 67% (703) were for-profit and 33% (351) were non-profit. The total PCH capacity on average in 2023 was approximately 63,462, with the total number of persons served at approximately 39,399. This demonstrated an occupancy rate of approximately 62%. The average maximum capacity of a personal care home was 60.

Residents of a PCH pay for services, including room and board, with their own funds. For individuals receiving the Supplemental Security Income (SSI), the PCH is prohibited from charging more than the SSI benefit the resident receives minus any personal needs allowance. The personal needs allowance was increased to $85 a month in 2009 and is used by the resident for clothing, transportation, Medicaid/Medicare premiums/copays, medication copays and all other personal expenditures. In addition, the Commonwealth also provides PCH supplement payments each month. To be eligible for the PCH supplement, the resident must complete the application for PCH Supplement (PA 761) and meet the functional eligibility requirements. The PCH supplement was increased by $200 per month in January 2023, retroactive to July 2022 and is $639.30 per month for a single resident and $1357.40 for a couple. This payment is in addition to the SSI payment. Residents who received the state SSI PCH supplement comprised up to 12%

of all people served in 2022. Of the total number of PCHs, 45% served at least one person who received SSI.

Home and community-based services (HCBS) are generally not provided in the PCH setting unless that setting is also enrolled with the OLTL as a residential habilitation service. PCH Residents who receive HCBS through the OLTL's Community HealthChoices (CHC) and OBRA Medicaid Waivers must meet either the higher nursing facility clinical level of care eligibility (NFCE) or intermediate care facility for other related conditions (ICF/ORC) eligibility requirements to be eligible for those services. Residents living in other PCH settings are usually assessed to need the PCH level of care which is a lower level of need. A PCH may submit a waiver request to accept a resident who meets the NFCE level of care. The waiver may be approved if the PCH can provide or arrange for the skilled services or clinicians licensed and regulated by the Department of Health required to meet the Resident's support plan. OLTL's CHC and OBRA waivers specifically prohibit the delivery of HCBS in a PCH except for residential habilitation services.

In accordance with the federal waivers, residential habilitation may be provided in a licensed setting, including PCHs and ALRs. PCH providers may pursue enrollment with the Department as a residential habilitation provider if they meet the additional staffing and regulatory requirements designed to address the specific needs of residents in this setting. Federal regulations, however, still prohibit Medicaid reimbursement for room and board for these settings. Residential habilitation providers must meet the requirements of the Centers for Medicare & Medicaid Services established in 42 CFR 441.301, which detail acceptable qualities and characteristics of settings for Medicaid HCBS provided under 1915(c) waivers. This is the

only HCBS service/funding allowable for PCHs and there are no other HCBS waiver services that may be provided to residents in a PCH.

Assisted Living Residences

Similar to PCHs, ALRs serve individuals who require assistance and/or supervision with ADLs and IADLs, however these settings may also accept and serve individuals needing nursing facility level of care if the ALR can offer the care appropriate to meet the individual's needs. ALRs are designed to provide food, shelter, assistance or supervision, and supplemental health care services for a period exceeding 24-hours for four or more adults who are not relatives of the operator and who require assistance or supervision in matters such as dressing, bathing, diet, financial management, evacuation from the residence in the event of an emergency or medication prescribed for self-administration. ALRs must have a living unit of at least 225 square feet of space per individual, if two residents share a living unit then there must be at least 300 square feet per resident. The living unit must have a telephone, individual thermostat, kitchen space with sink, a bathroom, and a bedroom (only shared by 2 consenting adults).

It is important to note, that an ALR has a core and enhanced service package depending on the level of acuity and needs of the resident. DHS licenses ALRs through the regulations at 55 Pa. Code Chapter 2800. ALR services, however, are not funded by Medicaid. Residents in the ALRs also pay for their own services, including room and board. HCBS typically are not provided in an ALR, however, there is no prohibition like there is for the PCH setting.

As of September 01, 2023, there were 67 licensed ALRs in Pennsylvania. Approximately 57% (38) were for-profit and 43% (29) were non-profit. The total ALR capacity on average in 2023 was approximately 5573, with the total number of persons served at approximately 3590.

There were 5 SSI recipients served by ALRs. This demonstrated an occupancy rate of approximately 64%. The average maximum capacity of an ALR was 83.

DHS is already exploring with the CHC-Managed Care Organizations (CHC-MCOs) the possibility of offering assisted living as an alternative to other services covered under the Medicaid state plan. This is referred to as "in lieu of service" (ILOS). ILOSs are an available opportunity under managed care at the option of the CHC-MCO to provide a cost-effective, medically necessary service or setting to a CHC Participant as a substitute for a State Plan service or setting. Under this option, per Centers for Medicare & Medicaid Services (CMS) requirements, Medicaid payment for room and board would be excluded, but CHC Participants would have the opportunity to receive services through the ALR. Historically it has been difficult toto accurately project utilization and costs for CHC Participants. Taking this important first step will help to build towards the future network of care providers, evaluate potential regulatory changes for maintaining high quality services for CHC Participants, and enable DHS to gather critical data on utilization, service quality and cost for future considerations and potential expansion. ALRs participating in an ILOS must meet the requirements of CMS established in 42 CFR 441.301 which detail acceptable qualities and characteristics of settings for Medicaid HCBS provided under 1915(c) waivers.

Personal Care Home Licensing and Monitoring

The Department completed 2,434 PCH inspections in 2022. There were 19,479 regulatory violations found during the inspections, with an average of 9.5 violations with each full licensing inspection.

The most commonly found violations included: not following the prescriber's directions when administering medications, not reporting incidents or conditions within 24 hours, and not developing and implementing procedures for medications and medical equipment.

In 2022, the department received 1,715 complaints and 28,745 incident reports regarding PCH operations. Approximately 65% of the complaints required an on-site investigation. The Department issued 55 PCH enforcement actions, most of which were provisional (warning) licenses.

The department granted 30 PCH regulatory waivers and denied 2 waiver requests submitted by PCH Administrators. The most common waiver request was relevant to qualifications of direct care staff of which most were related to non-United States high school diplomas.

In 2022, the department redesigned the direct care staff training course and competency requirements and provided approximately 500 hours of free training to PCH providers. In addition, the department awarded 11 full scholarships for the required 100-hour Administrator Training course to PCHs serving residents who receive SSI. In 2022, the department also approved 9 scholarships for the Medication Administrator Training Program Trainer course.

DHS is committed to supporting PCH providers and is in the early stages of implementing a Community Resource Program that will embed a Community Resource Coordinator in each of the five licensing regions of the state. The Community Resource Coordinator will focus on working with PCHs that serve more than 50% of residents who are SSI recipients. They will conduct telephonic needs assessments with the PCHs and then engage and collaborate with the local Area Agencies on Aging and other community resources to support

meeting the PCH needs identified in their assessment. They will also provide additional technical assistance with the goal of supporting the PCH's continued success.

Assisted Living Residences Licensing and Monitoring

The Department completed 126 ALR inspections in 2022. There were 620 regulatory violations found during the inspections, with an average of 7.1 violations with each full licensing inspection.

The most commonly found violations included: not following the prescriber's directions when administering medications, not reporting incidents or conditions within 24 hours, and not developing and implementing procedures for medications and medical equipment.

In 2022, the department received 2503 complaints and incident reports regarding ALR operations. Approximately 82 % of the complaints required an on-site investigation. The Department issued 3 enforcement actions, most of which were provisional (warning) licenses.

Requirements for Home and Community Settings

It is important to understand that OLTL's CHC and OBRA Waivers are 1915(c) waivers and services and settings within those programs need to meet specific requirements for home and community-based settings. For 1915(c) home and community-based waivers and, for 1915(i) State plan home and community-based services, home and community-based settings must have all of the following qualities defined at §441.301(c)(4) and §441.710 respectively, and such other qualities as the Secretary of the Department of Health and Human Services determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

• The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

• The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

• Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

• Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

• Facilitates individual choice regarding services and supports, and who provides them.

• In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following additional conditions must be met:

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other

designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

2. Each individual has privacy in their sleeping or living unit:

- Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
- Individuals sharing units have a choice of roommates in that setting.
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

3. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

4. Individuals are able to have visitors of their choosing at any time.

5. The setting is physically accessible to the individual.

6. Any modification of the additional conditions specified in items 1 through 4 above, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

• Identify a specific and individualized assessed need. • Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

• Document less intrusive methods of meeting the need that have been tried but did not work.

• Include a clear description of the condition that is directly proportionate to the specific assessed need.

• Include regular collection and review of data to measure the ongoing effectiveness of the modification.

• Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

• Include the informed consent of the individual.

• Include an assurance that interventions and supports will cause no harm to the individual.

Settings That are Not Home and Community-Based: For 1915(c) home and community-based waivers, settings that are not home and community-based are defined at §441.301(c)(5) as follows:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;

- A hospital; or

- Any other locations that have qualities of an institutional setting, as determined by the Secretary of the Department of Health and Human Services.

Thank you again for the opportunity to testify on long-term care settings and thank you for your continued support of Pennsylvania's seniors and adults with physical disabilities.