

**Freedom's Trail**  
*A disability civil rights agenda*

**Mass Home Care**  
**2009 Legislative Package**

- An Act Regarding Spouses As Caregivers
- An Act Regarding and Supervision in the Personal Care Attendant Program
- An Act Eliminating Age Discrimination In MassHealth
- An Act Regarding MassHealth Applications
- An Act Establishing A Public Guardianship Commission
- An Act Relative To Allowing For The Supervised Delegation in the Home of Certain Nursing Services

**Introduction: Why Freedom's Trail?**

The six bills included in Mass Home Care's legislative agenda for 2009 are all united by one common theme: **they enhance the independence of individuals with disabilities.**

Our Mission at Mass Home Care is what we call the "Three Possibles." We seek to keep people living in the least restrictive setting possible, at their highest level of functioning possible, for as long as possible.

These bills all do that. Our legislation will:

1. Allow a spouse to be a paid caregiver to keep a loved one out of an institution.
2. Broaden the Personal Care Attendant program to help people who have some form of cognitive impairment that requires them to be supervised or cued to accomplish the daily activities of living.
3. End age discrimination in the MassHealth program that forces some people to lose their Medicaid coverage when they turn 65.
4. Allow people to seamlessly transfer from an acute care setting to community care while their Medicaid application is being finalized.
5. Create a public guardianship program to help people who need this service in order to remain living as independently as possible.
6. Allow home health aides to help individuals with disabilities take their medications in a home setting, under the supervision of a nurse.

These are all bills that will help people—in seemingly small ways---to live in the most integrated setting possible. These are therefore civil rights bills flowing out of the Americans With Disabilities Act. That's why we are calling them part of "Freedom's Trail."

With your help, we will bring this package of bills to the Governor's desk.

## Fact Sheet: Spouses As Caregivers

### An Act Regarding Spouses As Caregivers.

*Lead sponsors: Rep. Barbara L'Italien, Senator Pat Jehlen*

*Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:*

SECTION 1. Section 9 of Chapter 118 E is hereby amended by adding in the second sentence of the second paragraph, after the words "requirements for Title XIX" the following new language:--

"Any program of home and community based services funded pursuant to the provisions of this chapter or pursuant to the provisions chapter one hundred and eighteen G, in which family members are permitted to serve as paid caregivers, shall include spouses within the definition of family member."

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**Background:** Currently, some MassHealth programs allow family members to be paid caregivers. This is true for the Adult Foster Care program, and for the Personal Care Attendant program. But these same programs do not allow "spouses" to count as family caregivers. In the PCA program for example, a son or daughter, a grandson or granddaughter, aunt, uncle, niece nephew, friend, or stranger can be paid as a caregiver---but not a spouse. (130 CMR 422.411 9.00A1a.)

As a result, many disabled individuals are denied care from the person closest to them, whom the trust the most, and who cares for them the most. Many consumers do not want to turn to children---or strangers---to provide their care.

In Governor Patrick's Community First Olmstead Plan, under the goal of "Improve the Capacity and Quality of Community-Based Long-Term supports, under Objective 1 (b) it states:

b) Determine options for supporting caregivers across the system of long term supports. Analysis would include evaluation of viability and appropriateness of paying spouse as caregivers in the delivery system.

A number of other states have already moved beyond Massachusetts in this regard. The federal government allows states to include spouses as paid caregivers in Medicaid programs. A number of states have been allowing spouses to be paid as caregivers for years. For example:

- In 2004 **California** submitted a Section 1115 Independence Plus application to the Center for Medicare and Medicaid services to provide aged, blind and disabled adults and children with self-directed personal care assistance and service delivery options. These self-directed services and options have enabled participants to remain in their family residence or in their own homes and helped to avert the need for

higher cost services such as nursing facility. Eligible elders and persons disabilities are allowed to select a spouse or parent to provide those services to them. 1

- **North Dakota**, as part of its efforts to increase alternatives to nursing homes, uses state funds to provide monthly payments to spouses and other family members to care for low-income people with disabilities, including older people living at home. About 40% of the Family Home Care caregivers are spouses. 2
- **Vermont's** 1115 waiver project includes in its core services expanded access to "the use of relative caregivers on a compensated basis to include personal care services provided by a spouse." 3
- **Minnesota's** Consumer Directed Community Supports program allows funds to be "used to pay parents of minor recipients or spouses of recipients for personal assistance services." 4 In the Minnesota plan, married individuals must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the community support plan. This program was approved by CMS in 2004.
- Medicaid's Cash & Counseling allows enrollees to use their personal assistance budgets to hire their own personal care aides. Cash & Counseling allows people to hire whomever they want to provide their care, and pay a friend or relative to do it. The services paid for by the state are all part of the elder's authorized Medicaid care plan. What's different is that, in many cases, family members—including spouses--and friends chosen by the elder are providing those services instead of an agency worker. Cash & Counseling grants exist in **Arkansas, Florida, New Jersey, Alabama, Illinois, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington and West Virginia.**

This legislation does not change the program eligibility rules for enrollees in any way. Instead, it broadens the range of people who can serve as a paid caregiver. This bill therefore does not expand the eligible population, or make any individuals newly eligible---it only provides them with a more flexible choice of who will provide their personal care.

#### Footnotes:

1. **California Independence Plus Section 1115 Demonstration FACT SHEET. CMS.**
2. [www.cms.hhs.gov/PromisingPractices/Downloads/ndscf.pdf](http://www.cms.hhs.gov/PromisingPractices/Downloads/ndscf.pdf)
3. [www.dad.state.vt.us](http://www.dad.state.vt.us). The Vermont Long Term Care Plan.
4. [www.cashandcounseling.org/resources/200160112-105946/mn\\_cdcsupports.pdf](http://www.cashandcounseling.org/resources/200160112-105946/mn_cdcsupports.pdf)

## **Fact Sheet: Cueing and Supervision in the Personal Care Attendant Program.**

### **An Act Relative to Cueing and Supervision in the PCA Program**

**Lead Sponsors: Senator Gail Candaras, Rep. Mary Grant**

*Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:*

SECTION 1. Section 12 of chapter one hundred and eighteen E as so appearing, is hereby amended in the first paragraph by inserting at the end thereof the following new sentence:-

“Notwithstanding the provisions of any general or special law to the contrary, the division shall develop or amend any standards and regulations applicable to the personal care attendant program to include as eligible members those individuals who are otherwise eligible for said program, but who require supervision and cueing in order to perform two or more activities of daily living.”

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**Background:**

The Personal Care Attendant (PCA) program is one of the largest MassHealth funded community-based long term care program in the Commonwealth. Enrollment in the PCA program went from roughly 5,800 members in 2000, to 16,955 members by 2008, and total expenditures for PCA services came to \$314.2 million in FY 2008. This program is open to people of all ages, including the elderly, younger adults with disabilities, and children with disabilities.

The average cost per member in the PCA program is approximately 32% of the cost of nursing home care. 1 This means that three members can be supported in the PCA program for every one placement in a nursing facility.

Under the PCA program regulations (130 CMR 422.000), a member is eligible to receive care if they require “physical assistance with two or more of the following Activities of Daily Living: (a) mobility, including transfers;(b) medications,(c) bathing/grooming;(d) dressing or undressing;(e) range-of-motion exercises;(f) eating; and(g) toileting.”

Personal care services are defined as “physical assistance with ADLs and IADLs (instrumental activities of daily living) provided to a member by a PCA in accordance with the member’s authorized evaluation or reevaluation, service agreement...”

Activities of Daily Living under the PCA regulations are activities “performed by a personal care attendant (PCA) to physically assist a member to transfer, take medications, bathe/groom, dress and undress, engage in passive range of motion exercises, eat, and toilet.”

The regulatory restriction to “physical assistance” means that a person who has suffered a stroke, and is currently unable to remember to bathe, or dress, or eat---but who is capable of doing all these things once prompted to do them---cannot receive personal care services in a community setting. PCA therefore has been defined as a ‘hands on’ program, which limits its Community First mission.

A person suffering from Alzheimer's, or other forms of serious cognitive impairment, who is unable to remember to do their activities of daily living, cannot get PCA support. If a person happens to have the 'wrong' kind of diagnosis, like a brain injury or dementia---they are unable to remain living in the most integrated, least restrictive setting. Yet if these same individuals require personal care, the state is willing to pay for their services in a nursing home. These individuals need personal care services to live in the community, along with someone to cue or prompt them, and supervise their ADLs and IADL care. To get into the PCA program, a member has to have two ADL impairments. Under current rules, if a member has one impairment that requires hands on assistance, and a second that requires cueing, they would not get into the program. As the PCA program is currently regulated, it has become an "Institutions First" program for people whose disability prevents them from self-cueing.

This is a form of discrimination against certain individuals with a disability, based on diagnosis. This serious shortcoming in the PCA program can be remedied by legislation which requires that persons otherwise eligible for the PCA program would be able to get care if they needed cueing or supervision.

Over the past year, a group of Personal Care Attendant program managers, and disability rights advocates, have been meeting to recommend improvements to the state's Personal Care Attendant (PCA) program. This includes ASAPs and Independent Living Centers (ILCs). In September of 2008, this "PCA Improvement Workgroup" submitted their recommendations to the Executive Office of Health and Human Services. In their list of recommendations was the following:

"The PCA program should be tailored to support the maximum level of consumer direction, including authorizations for **cueing and supervision** and services offering case management, supported living, and more effective and flexible surrogacy services."

If people in need of cueing and supervision are forced to go into a nursing home instead, the latter is a costlier and more restrictive setting than is required. Maintaining individuals in the PCA program can be significantly cheaper than in a nursing home.

In May of 1998, the federal Center for Medicare and Medicaid Services made supervision or cuing so that a person can perform tasks by him/herself an allowable service. Almost 70% of the states offering personal care through a HCBS waiver, viewed supervisory services, frequently referred to as cuing, as a component of personal care. 2

In their letter to State Medicaid Directors, CMS stated: "We plan to define personal care services in terms of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). ADLs...and IADLs...will be defined to clarify to States that personal care services can go beyond physical tasks to include assistance with cognitive tasks as well as services to prevent an individual from harming him or herself. We anticipate that this clarification...will help States better meet the needs of special populations who may require physical and cognitive impairment support in their daily lives. This legislation will help Massachusetts 'better meet the needs of special populations' through the PCA program. It

will also more efficiently use state funds for long term care, since three members can be served in the PCA program for every one placed in an institution.

**Footnotes:**

1 The FY 2008 cost of nursing home services (excluding other state plan services) was \$158 per day, or \$57,670 per year, according to MassHealth. The average PCA cost was \$18,532 per year.

2 “State Medicaid Programs Offering Personal Care Services”

Allen J. LeBlanc, Ph.D., M. Christine Tonner, M.P.H., and Charlene Harrington, Ph.D., Health Care Financing Review, Summer 2001.

## **Fact Sheet: Eliminating Age Discrimination In The MassHealth Program**

### **An Act Eliminating Age Discrimination In The MassHealth Program**

**Lead Sponsors: Rep. KathiAnn Reinstein, Senator Pat Jehlen**

*Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:*

SECTION 1. Section 12 of chapter one hundred and eighteen E is hereby amended by adding at the end thereof, the following new language:

--The Division shall ensure that the income and asset criteria for individuals over age 65 shall be no stricter than the income and asset eligibility for disabled individuals under age 65 as of July 1, 2008.

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**Background:** This legislation ends a form of age discrimination in the MassHealth program that has existed since the program was first implemented in Massachusetts roughly in 1965.

MassHealth is the key health insurance program for low income people in the Commonwealth. It covers more than one out of every six residents of Massachusetts. It provides for Doctor’s services, hospital bills, prescription drugs (Medicare Part D for dual eligibles), skilled nursing facilities, home health care, adult day health, dental (adults as of 7-1-06) eyeglasses (as of 7-1-06), durable medical equipment (may need prior approval).

In FY 2007, there were 1.082 million Massachusetts residents enrolled in MassHealth, of which 11% (119,000) were seniors. In terms of expenditures, seniors cost 29% of the \$7 billion MassHealth budget, or \$2.03 billion. About \$1.6 billion of that cost (79%) was for nursing home care. In recent years, Massachusetts has been pursuing an effort to “rebalance” long term care spending. “Expanded access to community-based services is both desirable from a quality of care standpoint,” explains the Massachusetts Medicaid Policy Institute, “and, in many cases, more cost effective than institutional care.” 1

Put simply, the MassHealth program has different eligibility standards for applicants regarding their income and assets that are based solely -on age, and this legislation would require that an adult seeking MassHealth assistance would find the same rules regarding income and assets, regardless of their age. Current regulations force some people to lose critical MassHealth insurance when they turn 65 years of age.

**Separate & Unequal:** People over the age of 65 and younger individuals with disabilities are both considered to be “categorically eligible” for MassHealth. But the basic financial eligibility rules change as you age, and differ in three basic areas: income, assets, and spend down rules:

- **For disabled individuals** under age 65, the income limit is 133% of poverty (around \$1,154 per month). If a disabled person has too much income, they are subject to a one-time spend down, and then they get onto Commonwealth. There is no asset test at all for individuals under the age of 65.
- **For people 65 and over**, the income limit is 100% of poverty, plus \$20/month, or \$887 per month. Elders have to meet income limits that are 23% lower than for younger people. The income spend-down rules for seniors requires a potential spend down every six months, causing some seniors to transition in and out of MassHealth eligibility. For example: an elder must accumulate current and old medical bills (paid and unpaid). A person with \$1,000 a month income, has to spend down to \$542 a month, which is \$458. that spend down amount is multiplied by 6 to equal a spend down of \$2,748. An elder must produce medical bills of \$2,748 before getting on MassHealth. Once they are on MassHealth, six months later they have to do the same spend down all over again. (Some elders on personal care attendant services have a smaller spend down, and people in the 1915c home care waiver can have 300% of SSI, or \$1,911/month, and still get into the waiver.) The most egregious difference for seniors is the asset test, which is \$2,000 for one person, \$3,000 for a couple. If you exceed this limit, which has not changed in 40 years, you cannot get onto MassHealth. (In the 1115 waiver now being reviewed by the federal government, seniors could have up to \$10,000 assets. But this will affect only 15,600 people.) A person’s home, car and burial trust don’t count towards the \$2,000 limit, but the cash value of insurance over \$1,500 does count.

Elders are subjected to more restrictive income, asset and spend down rules than younger disabled people. As the Massachusetts Medicaid Policy Institute has said, “People over age 65 generally must have income at or below the federal poverty level and minimal assets, although they may qualify with higher incomes or assets if they have sufficiently large medical expenses.” Many children and disabled on MassHealth can qualify with income up to 300% of the federal poverty level, while people 65 and older are limited to income at 100% of the federal poverty level.

This legislation levels the playing field for adults on MassHealth by making the income and asset rules for people age 65 and older no stricter than the income and asset eligibility for disabled individuals under age 65 as of July 1, 2008. Eligibility rules for people under 65 would not be changed at all. Only people over the age of 65 would be affected.

**Footnotes:**

1 "The Basics of MassHealth. Robert W. Seifert. Massachusetts Medicaid Policy Institute. Sept, 2008.

**Fact Sheet: An Act Regarding MassHealth Applications**

**An Act Regarding MassHealth Applications**

*Lead Sponsor: Senator Pat Jehlen*

*Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:*

SECTION 1. Section 9 of Chapter 118E of the General Laws, as amended by Chapter 211 of the Acts of 2006, is hereby amended by inserting, after the words "long-term care needs of the individuals," the following:-

The division shall provide, without requiring prior authorization, for up to sixty (60) days of eligibility for MassHealth Home and Community Based Services, including personal care services, for individuals who, upon discharge from an acute hospital, medical center, nursing facility, or health care facility including rehabilitation facilities and state hospitals, are presumed to be financially eligible for the MassHealth program and clinically eligible for home and community based services, as determined by an Aging Services Access Point or an Independent Living Center; provided further the division shall promulgate such standards and regulations as may be necessary for the administration of said presumptive eligibility program.

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**Background:** This legislation amends the MassHealth statute to expedite the process of enrolling the elderly and individuals with disabilities into a home and community based program. The legislation only affects people on MassHealth, and only those who are trying to get into the least restrictive settings in community-based care. The purpose of the bill is to make getting into home care programs as simple and expedited as it is currently to be placed in a nursing home---so that there is no incentive to place people in institutions over community care.

Individuals being discharged from a hospital or who are facing a crisis in the community may apply for admission to a nursing facility or for home and community based service waiver programs. The eligibility process may not always reflect the importance of long term care in the overall scope of the Medicaid program. Determinations must be made for the individual's financial eligibility for Medicaid and their functional eligibility for a specific MassHealth program or waiver.

In Massachusetts, the “Senior Medical Benefit Request” for long term care is 13 pages long, and it requires the senior to supply data from bank accounts, pensions, life insurance policies, medical bills, annuities, alimony, dividends or interest, trusts, veteran’s benefits, rental income, health insurance, long term care insurance, stocks, bonds, savings, mutual funds, house deed, pre-paid burial trusts, etc. The “Mass Health And You” guide for seniors needing long term care services is more than 28 pages long. No wonder then that seniors take weeks to pull together all their documentation and proof---before the state review process even begins. For a person trying to be placed from a hospital into home care, we don’t have the luxury to wait a month or longer for all the processing to be completed. Presumptive eligibility solves this process issue in a timely way, and is very targeted to people who appear MassHealth eligible, and who need complex care in the community.

Federal rules require determinations of financial eligibility for Medicaid must be made within 45 days from the date of application and up to 90 days when a disability determination must be made. However, service plans for people in crisis often depend on the availability of home and community based services when the person leaves a hospital or has a crisis. State officials and case managers often contend that a delay in determining financial eligibility may dictate whether a person remains in a community setting or enters a nursing facility. One way to shorten the processing of the long and complicated MassHealth financial eligibility application is to give a potential enrollee who appears to be financially eligible a “presumptive eligibility” on a temporary basis until a final determination is made based on their income documents.

A report to the Center for Medicare and Medicaid Services from the Medstat Group, Inc. on presumptive eligibility reported that almost half of all nursing home residents are admitted from hospitals and another 11 percent are admitted from other nursing homes. Just under 30% come from private or semi-private residences.<sup>4</sup> Delays in determining Medicaid eligibility may affect the decision about where services may be available. Nursing homes are more willing to admit individuals while their Medicaid application is pending. Residents who are found ineligible, or their families, can be charged for services delivered and expected to pay. Nursing homes are able to measure the resident’s income and resources and judge whether they will become a Medicaid beneficiary or remain private pay.

Federal law recognizes the importance of determining financial eligibility quickly for certain categories of beneficiaries such as pregnant women, children under the age of 19 and breast or cervical cancer patients. Federal policy allows states to receive federal reimbursement for services provided between the date of “presumed” eligibility and the actual determination of eligibility even when the presumption was determined to be in error. Current Federal policy does not allow states to receive reimbursement for services delivered to applicants while their eligibility is being decided. President Bush proposed legislation in April of 2004 to allow presumptive eligibility for individuals who are being discharged from a hospital to a Medicaid home and community based waiver program. The President proposed to allow states the option of providing community-based care with services for up to 90 days while Medicaid eligibility is being determined.

States recognize the importance of determining financial eligibility quickly. At least two states, Oregon and Washington, assigned responsibility for determining Medicaid eligibility for individuals applying for long term care services to the same agency that manages Medicaid long term care services. This organizational arrangement gives the agency responsible for all long term care policy and management responsibility better and more timely control over eligibility determinations and therefore access to services.

Presumptive eligibility allows eligibility workers or case managers, nurses or social workers responsible for the functional assessment and level of care decision to decide whether the individual is likely to be financially eligible and to initiate services before the official determination has been made by the eligibility staff. Applicants may be presumed eligible by the care coordinator staff responsible for conducting an assessment, determining level of care and authorizing home and community based waiver services.

Eligibility in Michigan and Ohio is presumed by Area Agencies on Aging without an arrangement with the State Medicaid Agency. In Ohio, the practice was designed by the Department of Aging and the AAAs. In these instances, there is no risk to Medicaid since inaccurate decisions are the responsibility of the Area Agency on Aging or the state aging agency which uses administrative funds to pay for services when Medicaid is not available. Another form of presumptive eligibility operates in states with programs funded with state general revenues. In these programs, the care coordinator determines that the person is eligible for the state program and may be eligible for the Medicaid waiver program. Services are initiated under the state program while the Medicaid application is processed. Once found eligible, the individual is enrolled in the waiver program retroactively to the date of application and services are billed to Medicaid.

The following section presents examples of presumptive eligibility programs in other states:

### **Washington**

Aging and Disability Services Administration (ADSA) developed a system for long term care programs for adults with disabilities and elders that include presumptive eligibility. Social workers/nurses that conduct assessments and authorize long term care services and the financial eligibility workers are located within ADSA. The process allows social workers or nurses to authorize delivery of essential services before the full eligibility process is completed. It is used when the case managers has sufficient financial information including a statement or declarations by the individual that lead staff to the reasonable conclusion that the applicant will be eligible. The case manager consults with the financial worker, completes an assessment and service plan and authorizes services for 90 days. Case managers and financial eligibility workers are employed by the same state agency. The individual must submit a formal application within 10 days. Individuals sign a fast track agreement that specifies in which the individual says:

"I \_\_\_\_\_ understand that the services I will be receiving are temporary pending my Medicaid financial eligibility and may be authorized for a maximum of 90 days. I agree to apply for Medicaid by \_\_\_/\_\_\_/\_\_\_ (10 days from the starting date of services). Failure to apply for Medicaid will result in the

termination of services. A determination of financial ineligibility will result in termination of services effective the date of the determination by financial services. I also understand that adjustments in my participation may be necessary when financial eligibility is determined. If I am determined to be financially eligible, services will be extended beyond 90 days."

The agreement is signed and dated by the individual and the worker.

Eligibility workers are able to "presume" eligibility and approve Medicaid coverage in a day if it means that a beneficiary can receive services in a residential or community setting instead of a nursing facility. Applicants are not required to make an appointment and come to a state office. Applications can be taken over the phone, by mail or during a home visit by the eligibility worker. Home visits facilitate the process and avoids delays when family members arrive at a state office without necessary documentation which requires a return visit once the papers are located.

In the person's home, documentation can be located quickly. Case managers may help the person or family member complete the application and send it to the eligibility worker. The expedited process has reduced the average time required to make decisions from 37 days to 17 days.

The social worker obtains information from the individual and consults with the financial eligibility worker. Information that requires further review (trusts, real estate holding) or raises questions about the final decision preclude the use fast track. If the information obtained by the social worker seems clear, eligibility workers may "presume" a person is eligible before the application is completed and verified. A decision can be made by the eligibility worker based on "self-declaration" or information supplied by the applicant. Presumptive eligibility is only available to people who intend to receive home and community based services in their home or a residential setting. Full applications must be completed within 90 days or home care services stop. Once the applicant is presumed eligible, the social worker enters the approval in the social services payment system using the program code appropriate to the applicant's eligibility category.

Since FFP is not available for services delivered if the applicant is not eligible for Medicaid, state funds are used to pay for services in the few instances in which the applicant is found ineligible. State officials believe that the risk is limited compared to the savings realized by serving a person in the community. Washington officials have determined that presumptive eligibility clients save Medicaid an average of \$1964 a month by authorizing community services for people who would have entered an institution if services were delayed.

While states do not receive FFP when they presume financial eligibility, they may presume disability and provide Medicaid coverage while the disability determination is being made. If, after the review, the applicant is found not to meet the disability definition, FFP is available for the costs of services provided during the period of presumptive disability.

## **Kansas**

The Kansas Department of Aging conducted a pilot presumptive eligibility project in 1999 under direction from the state legislature. The pilot was evaluated by the University of Kansas, School of Social Welfare.<sup>6</sup> The goal of the pilot was to initiate home and community based services within five days for customers who were likely to be eligible for Medicaid. A screening tool was developed to select applicants with the greatest need for home and community services and likelihood of being eligible. Individuals who were receiving SSI or already Medicaid beneficiaries were not included. Applicants whose income was reported to be less than the protected income level were selected.

Area Agency on Aging case managers were authorized to initiate services for individuals who were likely to be determined eligible for Medicaid. The screening tool was tested on 125 completed applications and found reliable. Case managers first completed the functional assessment. The financial screen was applied when the assessment indicated they met the level of care criteria. The pilot allowed services to be provided for a maximum of 60 days and individuals had to complete and submit a Medicaid application within ten days.

None of the customers who were presumed eligible entered a nursing home within 45 days while 11 who did not meet the screening criteria but were later found eligible for Medicaid did enter a nursing facility. The University of Kansas study concluded that the project would be cost effective if only five the 24 presumed eligible would have entered a nursing facility and stayed for seven months.

An agreement was signed by the applicant that included a page that the applicant signed attesting to the accuracy of the information provided. The form indicated that the services were temporary and a completed Medicaid financial application had to be submitted within ten days. Services would continue for 60 days from the date the completed application is submitted to the office responsible for determining financial eligibility. If the person were not eligible, services would terminate within ten days of the decision.

The pilot had unexpected implications. Staff from the agency responsible for determining financial eligibility became aware of the importance of processing applications from individuals seeking long term care services, and the time between application and a decision was reduced. State officials found that the expedited process was able to initiate services within 10-12 days, about the same time as the standard process after the pilot was implemented. While there are anecdotal reports of longer delays, the expedited service delivery process has been terminated.

## **Michigan**

Area Agencies on Aging in Michigan have implemented a form of presumptive eligibility although there is not statewide policy on the practice. AAAs have several funding sources. Financial information is collected over the phone during the first screening call. During the call, the information and assistance staff explain that they may be eligible for Medicaid, that an application will be needed and what material should be located. A social worker makes a home visit to conduct the functional assessment. If eligible, the social worker asks the client/family member to sign a financial release form that allows the AAA to obtain

verifications from banks, insurance companies and other organizations. The social worker helps the client complete the financial application and brings a portable copier to duplicate verifications received from the applicant. Services are started based on the client's needs and available funding sources. The financial information is reviewed by a Medicaid specialist employed by the AAA. The specialists were formerly employed by the Family Independence Agency (FIA) which is a county office of the state agency responsible for financial eligibility and have a thorough knowledge of Medicaid eligibility rules.

Normally, an individual would contact the county FIA office to apply for Medicaid. FIA changed from generalists who processed all Medicaid applications to long term care specialists who are responsible for all nursing home and waiver applications. The change has made it easier for the AAA to establish good relationships, and to improve eligibility worker's understanding of the pressing needs of people who need services to remain in the community. The relationships have reduced the average time needed to complete the application to two weeks. FIA eligibility workers know that applications submitted through the AAA will be complete and less likely to require additional work. In an emergency situation, applications have been approved in a day.

Because the AAA has several sources of funding, they have the flexibility to initiate services knowing one of the programs will cover the cost of authorized services in the unlikely event that Medicaid is denied. Very few applications are denied but the AAA has a small pool of funds to cover such contingencies. This system is not used by all Medicaid waiver agents though most, if not all, AAAs were reported to have such a process.

## **Nebraska**

Nebraska allows presumptive eligibility for potential waiver clients when the client has signed and submitted a Medicaid application to the Medicaid eligibility staff. To avoid confusion with the federally approved presumptive eligibility option, Nebraska named its program "Waiver While Waiting." Financial eligibility is the responsibility of a state agency that is separate from the division responsible for waiver services. Service coordinators receive some training on the Medicaid financial eligibility criteria but do not advise applicants.

Service coordinators work closely with the financial eligibility worker to determine when a person may be presumed eligible. After the assessment has been completed and the level of care determined, clients are given a choice of entering a nursing home or receiving waiver services. The service coordinator contacts the Medicaid eligibility staff to determine if the applicant is likely to be Medicaid eligible. To receive services under presumed eligibility, the applicant must agree to complete the application, submit all necessary financial records and meet any cost sharing obligations. Applicants sign a consent form and a notation is made on the consent form indicating that the applicant is presumed eligible until a final Medicaid eligibility decision has been made. When approved by the financial eligibility worker, service coordinators may authorize ongoing waiver services and medical transportation services for clients while the application is being processed. Home modifications and assistive technology services may be not presumptively authorized.

The services coordinator maintains regular contact with the Medicaid eligibility staff until a final decision is made. If the client is found ineligible, the services coordinator sends a written notification to the client in writing that services are terminated and offers assistance and referrals to other programs or resources. A ten day notice is not permitted. In the few instances in which applicants were later found ineligible, Social Services Block Funds were used to pay for the services delivered.

## **Ohio**

The Ohio PASSPORT Program is a Medicaid waiver program administered by the Department of Aging through Area Agencies on Aging (AAA). Presumptive financial eligibility has been included since the program's inception as a pilot program in 1985. During the initial home visit, the AAA case manager completes a functional assessment and determines the level of care. The case manager uses a worksheet (see appendix) to judge whether the applicant is likely to be eligible for Medicaid. Services may be initiated immediately if the case manager determines the individual is likely to be eligible. The case manager or a case aide may help the applicant complete the official Medicaid application and submit it to the county eligibility agency. The case manager or case aide is designated as an "authorized representative" and may be contacted by the county eligibility staff if further information or clarification is needed. Once the functional assessment is completed and the level of care is determined, the case manager enters the findings into the centralized eligibility system. The case manager enters a date of application which becomes the date of eligibility. The case manager is able to track the progress of the application through the computerized eligibility system and case aides follow up with the applicant if there is a delay in completing the application.

Over half of the applications for PASSPORT are processed through presumptive eligibility. Since its inception, the error rate is about 1% of applications. Costs for services delivered in error are covered by state funds from the Department of Aging. Providers are paid by the PASSPORT agency, submitted to the state Department on Aging which submits claims for Medicaid reimbursement to the state Medicaid agency.

## **Pennsylvania**

The Governor's Office of Health Care Reform, Department of Aging and Department of Public Welfare identified delays in approving eligibility as a barrier to effective management of long term care resources and offering timely access to home and community based services to applicants who could be served in community settings. Delays were attributed in part to the length and complexity of the application itself and the process used to review and approve eligibility. The Community Choices pilot program was designed to simplify eligibility and expedite determinations. The goal of the pilot is to ensure that no consumer enters a nursing home because of delays in processing their application for assistance. The project operates in two areas of Pennsylvania reduced the financial application from 12 to four pages and permitted self-declaration of income and assets. The Medicaid agency raised the asset test from \$2,000 to \$8,000 under Section 1902(r)(2) which allows states to use less restrictive income and asset tests. The increase enabled otherwise eligible individuals to

receive services in the community rather than entering a nursing home and spending down assets to the former level.

Area Agencies on Aging (AAA) are responsible for conducting assessments and determining the level of care decision using a revised "Community Choice Assessment Instrument." The program guidelines say that the assessment should be completed "with sufficient promptness to avoid any unnecessary nursing home placement (immediately, if necessary, but in all cases triaged in a manner that avoids unnecessary institutionalization)." The AAA case manager completes an abbreviated assessment to determine level of care during the initial visit. The case manager also gives the revised Medicaid financial application to the consumer and helps the consumer complete the application if requested. The financial application is submitted to the county assistance office which reviews the information as presented. The financial eligibility worker notifies the AAA case manager within two days of the decision. Less than 2% of the approved applications in the pilot have been approved in error. All applications for long term care services are processed under the expedited arrangement.

AAAs may initiate services for applicants who are eligible for waiver services "with sufficient promptness to avoid nursing home placement." If the applicant appears eligible for Medicaid but has not been determined eligible, AAAs are encouraged to serve the applicant immediately using funds from state general revenue programs. Once the financial determination is completed, services may be billed to Medicaid retroactive to the date of application.

*(Materials adapted from: "Expediting Medicaid Financial Eligibility" prepared by: Robert L. Mollica, National Academy for State Health Policy July 2004 )*

## **Fact Sheet: Establishing A Public Guardianship Commission**

### **An Act Establishing A Public Guardianship Commission**

**Lead sponsor: Senator Cynthia Creem.**

*Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:*

SECTION 1. Chapter 10 of the General Laws, as appearing in the 2000 Official Edition, is hereby amended by inserting after section 35T the following new section: --

Section 35U. There shall be established and set up on the books of the commonwealth a separate fund to be known as the Public Guardianship Commission Fund, to be used to meet the operational costs of the public guardianship commission established under the provisions of chapter 221D, in addition to any appropriation from the General Fund. Said fund shall consist of amounts received from public and private sources as gifts, grants, donations, bequests and devises of money any amounts to be received by said commission

in fees for services pursuant to sections 5 and 6 of chapter 221D. All revenues created under this section shall remain in said Public Guardianship Commission Fund, subject to appropriation, to meet the operational costs of said commission. All monies, as determined by the comptroller, remaining in the Public Guardianship Commission Fund, in excess of appropriations from the fund for the fiscal year then ending, shall on June thirtieth of each year be transferred by the treasurer to the General Fund unless the general court otherwise provides.

SECTION 2. Subsection (a) of section 6 of chapter 201 of the General Laws, as appearing in the 2000 Official Edition, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence: -- A parent of a mentally ill person, two or more relatives or friends of a mentally ill person, a nonprofit corporation organized under the laws of the commonwealth whose corporate charter authorizes the corporation to act as a guardian of a mentally ill person, the public guardianship commission or any agency with which it contracts for guardianship or conservatorship services or any agency within the executive offices of health and human services or educational affairs may file a petition in the probate court asking to have a guardian appointed for such mentally ill person and if, after notice as provided in section seven and a hearing, the court finds that he is incapable of taking care of himself by reason of mental illness, it shall appoint a guardian of his person and estate.

SECTION 3. Subsection (a) of section 6A of said chapter 201, as appearing in the 2000 Official Edition, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence: -- A parent of a mentally retarded person, two or more relatives or friends of a mentally retarded person, a nonprofit corporation organized under the laws of the commonwealth whose corporate charter authorizes the corporation to act as a guardian of a mentally retarded person, the public guardianship commission or any agency with which it contracts for guardianship or conservatorship services or any agency within the executive offices of health and human services or educational affairs may file a petition in the probate court asking to have a guardian appointed for such mentally retarded person.

SECTION 4. Section 7 of said chapter 201 of the General Laws, as appearing in the 2000 Official Edition, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence: -- Upon such petition the court shall cause not less than seven days notice of the time and place appointed for the hearing to be given to the alleged mentally ill or mentally retarded person, to the public guardianship commission if it or one of the agencies with which it contracts for fiduciary services is nominated, to the department of mental health in the case of a petition filed pursuant to section six, or the department of mental retardation in the case of a petition filed pursuant to section six A, and, if the alleged mentally ill or mentally retarded person is entitled to any benefit, estate or income paid or payable through the United States veterans' bureau or its successor, to said bureau or its successor, except that the court may, for cause shown, direct that a shorter notice be given.

SECTION 5. Subsection (a) of section 14 of said chapter 201 of the General Laws, as appearing in the 2000 Official Edition, is hereby amended by striking out the first sen-

tence and inserting in place thereof the following sentence: -- Upon the petition of any agency within the executive offices of health and human services or educational affairs, the public guardianship commission or any agency with which it contracts for guardianship or conservatorship services or other person in interest, the court may, if it finds that the welfare of a minor, a mentally ill or mentally retarded person, or person unable to make or communicate informed decisions due to physical incapacity or illness or spendthrift requires the immediate appointment of a temporary guardian of his person and estate, appoint a temporary guardian of such minor, mentally ill or mentally retarded person or spendthrift, with or without notice, and may in like manner remove or discharge him or terminate the trust; or in the absence or a person to serve as temporary guardian, the court by order or decree may authorize and monitor, as appropriate, medical treatment; provided, however, that if the court makes the findings required in paragraph (c), it shall authorize treatment with antipsychotic medication and shall, in the absence of a person to serve as temporary guardian, appoint a suitable person to monitor the treatment process to ensure that the treatment plan approved by the court is followed.

SECTION 6. Said chapter 201 of the General Laws is hereby amended by striking out section 16, as appearing in the 2000 Official Edition, and inserting in place thereof the following section: --

Section 16. If a person by reason of mental weakness is unable to properly care for his property, the probate court may, upon his petition or upon the petition of one or more of his friends, or of the public guardianship commission or any agency with which it contracts for guardianship or conservatorship services, or if a person by reason of physical incapacity is unable to properly care for his property, the probate court may, upon his petition or with his written assent, and in each case if after notice as provided in section seventeen and after hearing it appears that such person is incapable of properly caring for his property, appoint a conservator to have charge and management of his property, subject to the direction of the court.

SECTION 7. Section 16B of said chapter 201 as appearing in the 2000 Official Edition, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence: -- A parent of a mentally retarded person, two or more of his relatives or friends, a nonprofit corporation organized under the laws of the commonwealth whose corporate charter authorizes the corporation to act as a conservator of a mentally retarded person, the public guardianship commission or any agency with which it contracts for guardianship or conservatorship services or any agency within the executive offices of health and human services may file a petition in the probate court asking to have a conservator appointed for such mentally retarded person.

SECTION 8. Section 21 of said chapter 201, as appearing in the 2000 Official Edition, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence: -- Upon the petition of a person of mental weakness or of a friend or upon the petition of the department of transitional assistance, of the public guardianship commission or any agency with which it contracts for guardianship or conservatorship services or upon the petition or with the written assent of a person who by reason of physical incapacity is unable to properly care for his property, the probate court may, if it finds that

the welfare of the person of mental weakness or physical incapacity requires the immediate appointment of a temporary conservator of his property, appoint such temporary conservator, with or without notice, and may in like manner remove or discharge him or terminate his trust.

SECTION 9. The General Laws are hereby amended by inserting after chapter 221C, as appearing in the 2000 Official Edition, the following chapter: --

#### CHAPTER 221D.

#### PUBLIC GUARDIANSHIP COMMISSION

Section 1. (a) There is established under the general superintendence of the supreme judicial court a commission to be known as the public guardianship commission, composed of nine members who shall be appointed by the members of the said court. One member shall be nominated by the chief judge of the probate and family court department for the purpose of representing that court on the commission; at least one member shall be a person with a disability; at least one member shall be a person who is more than sixty years old; at least one member shall be a representative of an organization whose primary purpose is to advocate for persons with disabilities; at least one member shall be a representative of an organization whose primary purpose is to advocate for elderly persons; and at least one member shall be representative of elderly or other human service providers.

(b) Members of the commission shall serve for terms of five years, except that the original terms of membership shall be one one-year term; two two-year terms; two three-year terms; two four-year terms; and two five-year terms. No person shall be appointed to more than two consecutive terms on the commission.

(c) No less than thirty days prior to making any appointment to the commission, the justices of the supreme judicial court shall give public notice that a vacancy on the commission exists and shall give interested persons an opportunity to advise regarding the appointments.

(d) Any vacancy occurring on the commission shall be filled within ninety days by the justices. A person appointed to fill a vacancy occurring other than by expiration of a term of office shall be appointed for the unexpired term of the member he succeeds, and shall be eligible for appointment to one full five-year term.

(e) The commission shall elect from among its members a chairperson and any other officers it deems necessary.

(f) Five members of the commission shall constitute a quorum and five affirmative votes shall be required for any action or recommendation of the commission. The chairperson or any five members of the commission may call a meeting. Advance notice of all meetings shall be given to each member of the commission and to any other person who requests such notice.

(g) Members of the commission shall not be compensated for work performed for the commission, but they shall be reimbursed for their actual and necessary expenses.

(h) Within three months after the appointment of the first executive director, and at least every other year thereafter, the commission shall set priorities for service delivery. Prior to adopting a principal service delivery mode, the commission shall publicly solicit and take into consideration the views of clients, family members, advocates, providers of fiduciary services, affected government officials and others concerned with the plight of persons in need of such services. In order to establish a decentralized delivery system, the commission shall consider promotion and support of delivery of fiduciary services by local, non-profit organizations and encourage educational services and support to such families and friends of persons in need of fiduciary services as are willing and, with assistance, able to provide such services on a voluntary basis.

(i) The commission shall regularly report to the joint committee on human services and elderly affairs and to the house and senate committees on ways and means of the general court and to the justices of the supreme judicial court. The commission shall make its first report one year from the date this section takes effect and thereafter annually on the last day of July (except if such would be within six months of its first report), detailing (1) its priorities for service delivery and the reasons therefor; (2) the actions it has taken during the preceding year, including the number of persons served and the types of services provided to such persons; (3) a description of all funds, including state appropriations and other assistance received by the commission; (4) the names, duties and salaries of all individuals in its employ; (5) the money it has disbursed and any savings to the commonwealth which its services have produced; (6) a determination of the feasibility of utilizing volunteers to assist the commission in the delivery of services; and (7) a detailed plan and cost estimate for any recommended expansion of the service, including any savings to the commonwealth which such expansion might reasonably be expected to produce.

Section 2. (a) The policies and standards contained in this section shall be adopted and implemented by the commission through its rules and regulations, selection of and contracts with individuals and agencies to act as fiduciary or provide fiduciary services, decisions regarding persons being served or to be served by the commission, and other such ways as the commission may determine.

(b) A guardianship, conservatorship or other fiduciary relationship shall be established only when necessary to meet the needs of the incapacitated person and when such needs cannot be satisfied using a less restrictive alternative.

(c) Each such fiduciary relationship shall be established and structured so that the incapacitated person is allowed to make his or her own decisions to the maximum extent possible.

(d) A guardian, conservator or other fiduciary shall exercise authority only as necessitated by the incapacitated person's mental and adaptive limitations, and to, the extent possible, shall encourage the incapacitated person to participate in decisions, to act

on his or her own behalf and to develop or regain the capacity to manage personal affairs. A guardian, conservator or other fiduciary shall consider the expressed desires and personal values of the incapacitated person when making decisions and shall otherwise act in the incapacitated person's best interest and exercise reasonable care, diligence and prudence. It shall be assumed until demonstrated otherwise that such incapacitated person would choose to live in the least restrictive appropriate environment.

(e) With respect to each ward or proposed ward for whom the commission, or any individual or agency with whom or with which it contracts for fiduciary services, is responsible, the commission shall establish standards and procedures, and, subject to appropriation, bear the expenses, to ensure that:

(1) the ward will understand, to the maximum extent feasible, the nature and significance of any court proceedings;

(2) independent counsel is, to the extent necessary, made available to him or her for all court proceedings, or, when he or she so requests, in order to petition for discharge or removal of a guardian or other fiduciary;

(3) the commission shall immediately notify the court if the incapacitated person's condition is changed so that he or she is capable of exercising rights previously limited; and the commission shall cause an independent clinical review to be made at least annually to determine whether any fiduciary relationship created is still necessary, and if it is not necessary, that steps are taken to discharge the fiduciary;

(4) an annual accounting is made as required by procedures of the probate and family court department; and

(5) there is adequate monitoring and review of the quality of fiduciary services and of compliance with the policies, standards and procedures of the commission.

Section 3. (a) The commission shall, subject to appropriation, employ an executive director who shall be authorized to appoint such other staff, subject to appropriation, necessary to carry out the commission's duties pursuant to this chapter and chapter two hundred and one. The staff shall serve at the pleasure of the commission and shall not be subject to the provisions of chapter thirty-one or section nine A of chapter thirty. The executive director shall be responsible for the administrative operation of the commission and shall perform such other tasks as the commission may determine. The commission may employ, subject to appropriation, the services of experts and consultants necessary to carry out its duties and may also accept the services of volunteers, who may be reimbursed for their actual and necessary expenses incurred in carrying out their duties.

(b) The commission, pursuant to the provisions of section two of chapter thirty A, shall adopt such rules and regulations as are necessary to carry out the purposes of this chapter.

(c) The commission shall be subject to all laws and regulations governing the procurement by state agencies and commissions of supplies, services or construction.

Section 4. (a) Any resident of the commonwealth who is indigent (as defined in section twenty-seven A of chapter two hundred and sixty-one) and who is an incapacitated person for whom no other qualified person or organization is available and willing to accept appointment as guardian, conservator or other fiduciary, shall be eligible for the services of the commission.

(b) A court or other appointing authority shall not appoint as guardian, conservator or other fiduciary either the commission or any agency or individual contracting with the commission unless the court or other appointing authority first determines that no other qualified person or organization is available and willing to accept the appointment. In addition, in any case involving a minor, the court or other appointing authority shall not appoint as guardian, conservator or other fiduciary either the commission or any agency or individual contracting with the commission unless the court or other appointing authority first determines that responsibility for the minor cannot be accepted by the department of social services pursuant to chapter one hundred and nineteen. No court or other appointing authority shall appoint either the commission or any agency or individual contracting with the commission as guardian, conservator or other fiduciary of any eligible person unless the commission or the agency or individual contracting with the commission first determines, in accordance with this chapter and rules and regulations of the commission, and communicates with the court, that it, he or she has the capacity to provide high-quality fiduciary services and can otherwise carry out the responsibilities under such appointment; and any appointment in violation of this provision shall be void.

Section 5. (a) The commission may, subject to appropriation, contract with non-profit private agencies and individuals to serve as the guardian, conservator or other fiduciary or to provide guardianship, conservatorship or other fiduciary services to any individual for whom the commission has been or might be appointed such fiduciary; provided, however, that no such contract shall be entered into with a non-profit private agency unless the articles of incorporation of the agency authorize it to serve in such fiduciary capacity. Any such non-profit private agency or individual with which or with whom the commission so contracts shall in this section and in sections 6 and 7, be referred to as a "fiduciary agency."

(b) The commission or any fiduciary agency may serve as a plenary, limited or temporary guardian, guardian ad litem, conservator or monitor after appointment by a court pursuant to the law of the commonwealth, including but not limited to chapters nineteen A, one hundred and nineteen, one hundred and twenty-three, one hundred and twenty-three B and two hundred and one.

(c) The commission or any fiduciary agency may petition the court for appointment as guardian, guardian ad litem, or conservator. Any other petitioner for guardianship or conservatorship after preliminary investigation by, and approval of, the commission or fiduciary agency, as the case may be, may nominate the commission or such fiduciary agency as a guardian, guardian-ad-litem or conservator, with notice to the commission or fiduciary agency in accordance with chapter two hundred and one.

(d) The commission or any fiduciary agency may serve as trustee or other fiduciary, except an administrator or executor of an estate. Before serving as a trustee or fiduciary,

ary, the commission or fiduciary agency must receive court approval, except as provided in subsection (e).

(e) The commission or any fiduciary agency may serve as representative payee by appointment of the appropriate federal agency without court review or approval. A representative payee shall be considered a fiduciary for purposes of this chapter.

(f) The commission or any fiduciary agency, on its own motion or at the request of the court, may petition to intervene at any time in a guardianship or conservatorship proceeding to protect the best interests of the proposed ward.

(g) The commission or any fiduciary agency may provide information and assistance pertaining to guardianship, conservatorship and other fiduciary services, and may perform such other tasks as may be necessary to carry out its responsibilities under this chapter.

(h) The commission or any fiduciary agency shall maintain records of each case in which the commission or fiduciary agency provides guardianship, conservatorship or other fiduciary services. Each such case record shall include the financial and personal information necessary for the commission or fiduciary agency to carry out its fiduciary responsibilities. Such records shall be the property of the commission. Access to such records shall be limited to members and staff of the commission, to staff of the agency serving as the fiduciary of the subject of a particular record and to others pursuant to an order of a court of competent jurisdiction; provided, however, that authorized agents of the commonwealth, for auditing purposes, shall be afforded access to such records, with information which may be used to identify the subject redacted.

(i) The commission shall be eligible for and shall have the authority to accept any and all donations, grants, appropriations, bequests and devises of money, property, personnel services or other assistance which may be received from the commonwealth or any agency thereof, the United States or any agency thereof, and other governmental agency, any institution, person, firm or corporation, public or private; to be held, used or applied for any or all purposes specified in this chapter. No such assistance shall in any way compromise or limit the independence and autonomy of the commission or its authority to carry out the purposes of this chapter. Any funds received by the commission other than by appropriation shall be deposited into the Public Guardianship Commission Fund, as provided for in section 35U of chapter 10.

Section 6. (a) If the commission or any fiduciary agency is appointed a guardian, conservator or other fiduciary, it shall not charge for the costs of its services or the costs of the appointment or approval procedure against the property or income of the individual for whom it serves as fiduciary, unless the court or other appointing authority determines at any time after the commission's or fiduciary agency's appointment that the individual is financially able to pay all or part of the costs.

(b) The court or other appointing authority shall determine ability to pay by investigating the nature, extent and liquidity of assets and the disposable net income of the individual.

(c) The commission, through its executive director, may recommend fees to be assessed for its services in any individual case in which the ward is no longer indigent, in accordance with standards established in its rules and regulations. No fees may be assessed for fiduciary services unless the eligible person or ward is given written notice at the start of such services that such fees may be assessed.

(d) The commission shall deposit any payment of assessed fees into the Public Guardianship Commission Fund, as provided for in section 35U of chapter 10.

(e) The commission may claim the reasonable value of services rendered to any individual against his estate upon the death of that individual, if the individual was no longer indigent at the time of death.

Section 7. Notwithstanding any other law to the contrary, neither the commission nor any fiduciary agency shall be required to file a bond in individual cases in which the commission or a fiduciary agency is appointed to act in a fiduciary capacity but shall give a bond, with sufficient sureties, for the joint benefit of all persons for whom the commission or fiduciary agency is appointed to act in an amount not less than the value of all assets held by the commission and such contracted fiduciary agencies as of the last day of the most recent fiscal year, but at no time less than fifty thousand dollars. Such bond shall be filed with the chief judge of the probate and family court department, and a copy thereof shall be filed with the register of probate of each division of said court in which the commission or a fiduciary agency has been appointed to serve in a fiduciary capacity. The state treasurer may, subject to appropriation, set aside sufficient funds for the purpose of providing a surety for the commission's bond pursuant to this section.

Section 8. The books and records of the commission shall be audited by the state auditor within eighteen months after this chapter becomes effective as to Suffolk county, and every two years thereafter. A copy of such audit shall be sent to the clerk of the house of representatives who shall forward the same to the house and senate committees on ways and means and the joint committee on human services and elderly affairs.

SECTION 10. Section 1 of this Act and sections 1, 2 and 3 of chapter 221D of the General Laws, as inserted by section 9 of this Act, shall take effect on July 1, 2010.

All other sections of this Act, including the other sections of said chapter 221D, shall take effect on October 1, 2010, provided, however, that, at said effective date, the provisions of subsection (a) of section 4 of said chapter 221D shall apply only to Suffolk county.

Said provisions of subsection (a) of section 4 of chapter 221D shall apply to the counties of Plymouth, Worcester, Norfolk and Barnstable on January 1, 2010 and to all remaining counties on July 1, 2010.

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**Background:** Many elderly and disabled people do not have the capacity to decide where to live, what medications or medical care they need or how otherwise to spend their money. It may become necessary for a Probate Court to appoint a guardian or conservator

to make these decisions. Unfortunately, many of these incompetent people have no substantial assets and no family or friends to act as guardian or conservator, and volunteers are hard to find to take on this responsibility. When no one is found, decisions are not made, monies are not spent and, in some instances, services or benefits are not provided, often with the result that the incompetent person must be institutionalized, to the detriment of both the person and the taxpayers.

This bill establishes an independent and autonomous Public Guardianship Commission under the Supreme Judicial Court. The Commission (or a fiduciary non-profit organization with which it contracts) may be appointed as guardian, guardian-ad-litem, conservator, trustee, representative payee or monitor for an indigent, incompetent person for whom there is no one other than the Commission or its contractee to serve in this capacity. The bill does not change the law as to when a fiduciary may be appointed, but provides an organization that is available to act in this capacity when necessary. The bill would go into effect as a pilot project serving those in need only in Suffolk County.

The language of the bill makes it clear that the unpaid Commission will encourage and support families and friends to serve as fiduciaries, with assistance from the Commonwealth, if necessary; promote and support the provision of fiduciary services by local, non-profit organizations, in order to establish a decentralized delivery system; provide extra safeguards for the rights of wards and proposed wards; and thereby ensure that every person served is provided with caring, high quality and individualized service at a reasonable cost. Prior to adopting a service delivery model, the Commission must solicit and take into consideration the views of all interested persons.

The Commission or its contractee may be appointed as a fiduciary only when there is no less restrictive way of meeting the needs. All decisions of the fiduciary must reflect the individual character, desires and circumstances of the incompetent person; and the incompetent person must be allowed to make his or her own decisions to the extent possible. The fiduciary may not be appointed unless it first determines that it is able to provide high quality services. The nine member Commission includes an elderly person, a disabled person, an elderly advocate, a disability advocate and an elderly or human services provider.

## **AN ACT RELATIVE TO ALLOWING FOR THE SUPERVISED DELEGATION IN THE HOME OF CERTAIN NURSING SERVICES TO HOME HEALTH AIDES**

***Lead Sponsor: Senator Richard T. Moore***

### Section I

Section 80B of Chapter 112 of the General Laws, as appearing in the 2002 Official Edition is hereby amended by inserting in the last paragraph after the words "licensed practical nurse" the following:

"(8) the administration of or assistance with the administration of medications in the home by a home health aide as defined under G.L. c. 111, § 72F, provided that such an aide has completed agency training regulations to be drafted according to regulations promulgated by the Board of Registration in Nursing and the Department of Public Health and that the administration or assistance with administration is performed under the supervision of a registered nurse. The delegation permitted under this subparagraph eight shall be limited to medications which are oral, ophthalmic, otic, topical, intranasal, transdermal, suppository, prefilled, or products which are administered by inhalation. Administration of medications by intramuscular, subcutaneous, intradermal, intraosseous, intravenous shall not be permitted.

Agencies shall provide training and establish documentation protocols according to the nurse delegation model and regulations to be drafted by the Board of Registration in Nursing and the Department of Public Health. These regulations shall specify that the registered nurse delegator and the home health aide are accountable for their own actions in the delegation process and that no registered nurse shall be required to delegate if the registered nurse determines it is inappropriate to do so. These regulations shall specify that delegation of administration of medication does not alter the responsibility of the home health agency or hospice to teach and the patient/family to participate in learning, self administration of medications, whenever appropriate.

A nurse licensed under this chapter who delegates a specific nursing activity or task in compliance with the rules adopted in these regulations shall not be subject to disciplinary action by the board of nursing for the performance of a person to whom the nursing activity or task is delegated.

## Section II

Section 9 of Chapter 94 C of the General Laws is hereby amended by inserting in the first paragraph after the words "veterinarian when registered pursuant to the provisions of Chapter 7" the following:

"a home health aide pursuant to the provisions of G.L Chapter 112 S 80B (8)."

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### Background:

*"There was more RN involvement in care, and less unlicensed and unregulated practice with Nurse Delegation. Rather than bring higher risk tasks into the settings, Nurse Delegation has actually enhanced the quality and intensity of supervision."*

-Nurse Delegation Study, mandated by Washington State Legislature, 1998

**Purpose:** This bill seeks to refine the Commonwealth's Nurse Practice Act (NPA) to specify appropriate nurse delegation practices.

**Background:** To provide quality care to home health patients, other states like Oregon, Washington and New Hampshire have established successful state-based, nurse-directed

medication administration models, which, depending on the state, clearly differentiate delegation of administration by setting and/or patients.

~The Community First initiative submitted by Governor Deval Patrick looks to shift the majority of Medicaid dollars away from nursing homes and institutional care into home and community-based programs.

~Given this endeavor, along with the widespread effort to streamline state spending and the goal of improving quality care for a growing population of the senior community\*, the state must find ways to tap into the experience and assessment skills of registered nurses while allowing safe and appropriate delegation.

~Allowing appropriate delegation under the supervision of a skilled nurse would:

- Help improve patient care and safety.
- Increase the role of nurse oversight for many patients whose medication needs may otherwise not be properly addressed.
- Respond to the public policy agenda to develop state-level solutions that support long-term care in the least restrictive setting.
- Acknowledge the need for more nurses in home care with a plan to utilize their skills most effectively.
- Advance more cost-efficient care by reducing nursing home admittance and increasing seniors' independence through quality home health services.

\*Massachusetts ranks in the top 13 states with 52-65 nursing facility residents per 1,000 individuals over age 65 (The Lewin Group calculations based on Cowles, M. 2005 *Nursing Home Statistics Yearbook*)

**Summary:** Amends Section 80B of Chapter 112 as well as Section 9 of Chapter 94 C of the Massachusetts General Laws, adding language onto the definition of professional nursing and the administering and dispensing of controlled substances in the course of professional practice. The proposal:

- Allows the administering of certain medication to a home health patient by a trained and certified home health aide.
- To ensure accountability and responsibility, this proposal also requires that home health agencies provide training and establish documentation protocols (according to the nurse delegation model) and regulations drafted by the Board of Registration in Nursing and the Department of Public Health.
- Stipulates that any licensed nurse who delegates a task in compliance with the adopted rules shall not be subject to disciplinary action by the Board of Nursing for the performance of a person to whom the nursing activity or task is assigned.

**Contact:** Pat Kelleher, Executive Director, Home Care Alliance of Massachusetts  
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