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July 2, 2012

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

[Submitted Electronically]

Re: File Code CMS-2249-P2

President
Lance Robertson
Oklahoma

Vice President
Gloria Lawlah
Maryland

Secretary
Jay Bulot
Georgia

Treasurer
Lora Connolly
California

Dear Administrator Tavenner:

The National Association of States United for Aging and Disabilities (NASUAD) appreciates the opportunity to comment on the proposed rule **CMS-2249-P2: State Plan Home and Community-Based Services, 5 Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice**, as published in the May 3, 2012 *Federal Register*, volume 77, number 86.

NASUAD represents the nation's 56 state and territorial agencies on aging and disabilities. Each of our members oversees the implementation of the Older Americans Act (OAA), and many serve as the operating agency for Medicaid home and community-based services (HCBS) waivers that serve older adults, and in some cases, individuals with disabilities.

Accordingly, NASUAD members have a unique and critical perspective to offer CMS in its rulemaking process, and we respectfully submit these concerns and comments below:

Landlord/Tenant Laws. NASUAD is concerned that in provider-owned or controlled residential settings, according to the proposed rule, a unit or room is defined as "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 the tenants have under the landlord/tenant laws of the State, county, city, or other designated entity."

First, landlord/tenant laws are not always compatible with state licensure requirements. State assisted living licensure laws and regulations are expressly designed to regulate the contractual relationship between an assisted living provider and a resident, including conditions for discharge or transfer. Eviction standards for Medicaid HCBS settings for state-licensed facilities need to accommodate state regulations. Otherwise, existing home and community settings that otherwise align with CMS's proposed requirements would no longer fall within the scope of a home and community based setting under Medicaid. Such a classification change would likely reduce the number of available placements, therefore leading to otherwise avoidable institutionalizations.

Second, the application of landlord/tenant law to provider-owned or controlled residential settings is inherently problematic because the legal relationship between a provider and a resident is very different than that of a landlord tenant relationship. Unlike providers, landlords are not responsible for the health and welfare of their tenants. Consequently, circumstances leading to a tenant eviction are not likely to cause an imminent health risk to the individual or to other tenants. The same, however, cannot be said of circumstances leading to a discharge in assisted living.

Mandating eviction protections under landlord/tenant laws to residents of assisted living could pose serious harm in delaying move-outs when health risks to the resident or other individuals are deemed clinically necessary and appropriate and required by state licensure regulations. Instead of mandating eviction protections under landlord tenant laws, protections could instead be provided through specific disclosure provisions as part of the residency agreement and approved by the applicable state licensing authority. Such provisions would specify the terms and conditions for move-in, including conditions for discharge or transfer and an appeals process for resolving disputes that are non-emergency in nature.

Shared Units. Under the proposed rule, several conditions must be met in a provider-owned or controlled residential setting. For example, to ensure that "each individual has privacy in their sleeping or living unit," individuals may "share units only at the individual's choice..."

NASUAD is concerned that this language does not take into account the economic constraints under which most state Medicaid programs operate. Since Medicaid does not pay for room and board in HCBS settings, sharing units is often the only way that states are able to provide Medicaid coverage for services in certain settings. While every effort should be made to accommodate individual choice in sharing a unit, this proposed requirement could pose an economic hardship on a program that is trying to reasonably accommodate choice. NASUAD recommends the language be modified to ensure appropriate flexibility in protecting individual choice, while at the same time recognizing the economic realities of the lack of Medicaid funding for room and board.

Housing and Services. Though not included in the proposed regulatory language, CMS is considering adding a requirement to the conditions for provider-owned or controlled residential

settings that the “receipt of any particular service or support cannot be a condition for living in the unit.”

While NASUAD appreciates that CMS seeks to ensure that the individual is receiving a community-based service, attempting to decouple settings and services is unrealistic in many instances, as the setting itself is a service. Furthermore, separating the two would effectively limit the individual’s choice of setting by potentially excluding residential facilities from this definition.

Additionally, CMS must acknowledge that state-licensed assisted living/residential care facilities and service providers have a statutory responsibility to protect the individuals that live in such settings. Therefore, CMS should clarify that there is an exception to this proposed requirement for situations where the health or safety of the resident, other residents, or staff, is at risk. For example, among some residents with dementia, there is a high risk of injury unless they have a relatively high degree of supervision. Without such services, they may not be able to live safely in the unit.

Rebuttable Presumption. The proposed rule states that home and community-based settings do not include nursing facilities, institutions for mental diseases, intermediate care facilities for the mentally retarded, hospitals, “or any other locations that have the qualities of an institutional setting as determined by the Secretary.”

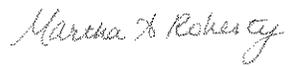
NASUAD is concerned about the approach that the CMS intends to take in considering whether a setting qualifies as “institutional” or not. That is, that the agency proposes to exercise a “rebuttable presumption that a setting is not” home and community-based, and would then “engage in heightened scrutiny for any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or, if a in a building on the grounds of, or immediately adjacent to, a public institution or disability-specific housing complex.”

This wording is too restrictive and NASUAD is principally concerned that the phrase, “on the grounds of or immediately adjacent to, a public institution or disability-specific housing complex” could eliminate many important resident-centered options for older adults and people with disabilities. For example, under this definition, continuing care retirement communities (CCRC) and other campus-type settings that meet specific disability needs, such as assisted living communities that include secured Alzheimer’s units, could be deemed institutional.

Accordingly, NASUAD recommends that being on the grounds of, or adjacent to, an institution not be classified as a disqualifying characteristic. Rather, CMS should adopt an approach that evaluates whether the community based setting supports the person-centered qualities of choice, dignity and independence outlined in the proposed rule.

On behalf of NASUAD, thank you for the opportunity to comment. We look forward to continuing to work with CMS on these issues throughout the rulemaking process and beyond. If you have any questions or concerns about these submitted comments, please do not hesitate to contact me at mroherty@nasuad.org, or Lindsey Copeland NASUAD's Director of Policy and Legislative Affairs, at lcopeland@nasuad.org.

Sincerely,

A handwritten signature in cursive script that reads "Martha A. Roherty".

Martha A. Roherty
Executive Director



June 14, 2011

Dr. Donald Berwick
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Washington, DC 20201

[Submitted Electronically]

Re: File Code: CMS 22296-P

Dear Dr. Berwick,

The National Association of States United for Aging and Disabilities (NASUAD) and the National Association of Medicaid Directors (NAMD) are pleased to offer joint comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule aimed at amending various provisions of the regulations governing Section 1915(c) Medicaid Home and Community-Based Services (HCBS) waivers, *Medicaid Program; Home and Community Based Services Waivers*, as published in the April 15, 2011 *Federal Register*, volume 76, number 73, pages 21311 to 21317.

Originally founded in 1964 under the name the National Association of State Units on Aging (NASUA), the organization changed its name to NASUAD in 2010 to formally recognize the work that the state agencies were undertaking in the field of disability policy and advocacy. Today, NASUAD represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support home and community based services for older adults and individuals with disabilities. The Association's mission is "to design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability, and their caregivers."

NAMD is a bipartisan, professional, nonprofit organization representing the nation's 56 state and territorial Medicaid agencies, including the District of Columbia, whose mission is to represent and serve state Medicaid directors. NAMD, formerly National Association of State Medicaid Directors (NASMD), was an affiliate of the American Public Human Services Association (APHSA) beginning in 1979. Medicaid has become the largest public assistance program in every state, the country's foremost program operating as a joint federal-state partnership, and will soon be the source of health insurance coverage for approximately one-sixth of the nation's residents. Federal reforms in 2010 also created explicit links between Medicaid and private health insurance markets. With these fundamental changes, the demands placed on Medicaid Directors have both grown and shifted in focus. NAMD was created to fulfill the need for a new and independent organization representing state Medicaid Directors and the programs they operate.

The members of our respective Associations have the primary authority for developing and operating HCBS waiver programs. Our members are undertaking challenging and important efforts to integrate programs to improve the options and quality of services available to Medicaid consumers, including those who need HCBS services. In general, NASUAD and NAMD support CMS' efforts to improve HCBS options for people and their families, as well

as to provide additional flexibility and guidance to the states. However, due to the potential impact of specific provisions included in the proposed rule, our Associations request a number of clarifications, as well as additional stakeholder dialogue. We offer these coordinated comments as a reflection of the integral working relationships at the state level, and the widespread agreement on the concerns and requests we make herein. Below, please find NASUAD and NAMD's jointly-issued general comments, followed by the two Association's joint comments and recommendations on specific provisions of the proposed rule.

I. NASUAD AND NAMD GENERAL COMMENTS

Combining Waiver Target Populations – Our Associations appreciate CMS' proposal to allow states to combine waiver populations. The notion of supporting whole families in their own homes is a concept that our organizations have long supported. However, we strongly encourage CMS provide more guidance on the Agency's expectations around service delivery and related documentation. Collectively, we also are concerned about quality measurement within a waiver serving populations with significantly different support preferences and needs, such as older adults and persons with intellectual and developmental disabilities (ID/DD). Current CMS quality requirements already are challenging. Additional complexity in quality improvement strategies could prove highly problematic and be a significant barrier to states interested in a combined population waiver.

Person Centered Planning – Again, states have long supported person centered planning and we appreciate CMS' efforts to offer more guidance on such models. However, experience has shown that older adults have very different perspectives on person centered planning and self-direction compared to young adults. Additionally, older persons with dementia may not be appropriate for self-direction. We are concerned about the proposed rule language, which appears to require full participant direction, when such a service arrangement may not be preferable or appropriate for certain populations. Additionally, the proposed language is silent on the role of legal guardians.

HCBS Setting – While our associations understand that CMS' guidance is intended to ensure HCBS settings truly are homes and are not "sign-flips" from small facilities to home-like, the proposed language is highly problematic. We believe that the language, as drafted, would reduce, and not expand, choice. Additionally, the assisted living framework could have serious implications for people who choose to live in assisted living settings. Specifically, the proposed language, which mirrors Money Follows the Person assisted living language, could eliminate most assisted living from Medicaid. A further concern is that assisted living is frequently the long-term services and supports point of entry for older adults who provide pay. If the proposed rule reduces the pool of Medicaid-participating assisted living settings, many older adults who spend-down to Medicaid while in assisted living settings could face eviction. The unintended consequence of the proposed language could be an increase in long-term stay nursing home admissions.

Administrative Proposals – We understand CMS' desire to improve federal-state communication and offer clear guidance on public comment. However, the changes in "substantive amendment" could prove problematic. Specifically, changing the effective date to the date of approval from the date of submission, and precluding retroactive application of the change(s), could present serious challenges to states in today's budgetary environment, as well as for state agencies under legislative mandates to implement changes or budget initiatives. Additionally, clear guidance on public notice expectations is needed. While public input is an important part of any waiver development or modification effort, requirements for extensive public input periods could prove challenging for analogous reasons.

II. NASUAD AND NAMD SPECIFIC COMMENTS AND RECOMMENDATIONS

Section 441.301(b)(1)(i) - The rule should clarify that the operating agency should have authority to approve the written services and supports plan when the Medicaid agency has delegated the operations of the Medicaid waiver. NASUAD and NAMD request that CMS add language stipulating that the operating agency should have

such authority when expressly delegated by the Medicaid agency. We recognize that the Medicaid agency would retain ultimate accountability for, and authority over, the 1915(c) waiver.

Section 441.301(b)(1)(i) - The requirement for person-centered services and supports planning is a welcome policy direction. Individuals utilizing waiver services will be assured that their personal preferences and goals will be valued and utilized as part of the assessment and planning process. However, the requirements of the person-centered services and supports plan would require additional resources for states that serve large targeted groups under separate waivers. These requirements would result in states redesigning their current assessment and planning tools to comply with the additional requirements proposed at (b) (1) (A) and (B). Such requirements, coupled with the changes in 441.301(b)(6), would be an administrative burden for states that currently have well-developed systems in place to serve targeted populations. Our organizations request that CMS clarify that certain principles for person-centered planning must be addressed but that states may meet the requirements of such principles in a variety of ways as negotiated between the states and the federal government.

Section 441.301(b)(1)(i) - While self-direction should be a goal for any individual receiving long-term supports, cognitive impairments; dementia; and criminal history must also be addressed in the planning process for services and community supports, while maintaining a focus on self-direction and quality of life. We request that CMS clarify the role of legal guardians or representatives in self-direction, as well as scenarios under which self-direction may not be appropriate, and how CMS will accommodate such individual preferences or needs.

Section 441.301(b)(1)(i)(A)(3) - In the person-centered planning process section of the proposed regulation, assessing and planning for an individual's needs in their own home and community is essential to gaining an accurate picture of the persons support needs. NASUAD and NAMD request that CMS specify that the plan development process be face-to-face, and that, whenever possible, the plan development process occurs in the individual's home and community at a time convenient to the individual.

Section 441.301(B)(1)(i)(B)(4) - In (B)(4), CMS indicates that the plan "reflect ... the providers of those services and supports." The current language implies that a plan would have to be updated whenever providers change; such a requirement would be burdensome on people, providers, and state systems. Our organizations request that CMS clarify that the plan need not be updated each time a provider changes.

Section 441.301(B)(5) - In regard to (B)(5), in addition to the services and supports provided and risk factors and measures to minimize risk, the services and supports plan should also address any identified service needs that are not being met, and allow the state to identify and plan for mitigating risks when an individual poses a danger to self or others due to serious cognitive impairments, severe dementia, or previous criminal involvement. Individuals may have certain needs unmet for a number of reasons. A risk plan that identifies risk factors may not always allow for a plan to minimize the risk or provide a back-up strategy if the individual is unwilling or unable to address specific needs. Individuals may be unable or unwilling to comply with all aspects of care planning. A services and supports plan should include areas where agreement cannot be reached between all parties where unmet needs and risks are identified, or where there are documented risks when the individual poses a danger to self or others. Our organizations request that CMS clarify the process for development and core elements of a risk plan.

Section 441.301(B)(6), and (B)(10) - In regard to (B)(6) and (B)(10), we believe involvement in all parties is problematic. In (B)(6), requiring "all individuals and providers" sign the plan could present a timeliness of service start date issue. Additionally, not all parties need to see the entire plan; stated another way, such a sign-off and distribution process, as noted in (B)(10) could raise privacy issues. NASUAD and NAMD recommend rephrasing (B)(6) and (10) to stipulate that only those selected by the participant and integral to implementation of the plan be required to sign and/or receive a copy of the plan.

Section 441.301(b)(1)(iv) - CMS' proposal to clarify community-based settings' characteristics is a positive step and should minimize the efforts to simply convert institutional settings into community-based care settings, while maintaining an institutional environment. However, NASUAD and NAMD believe that the proposed rule will have

far-reaching and unintended consequences, including reducing, rather than expanding, consumer choice. Additionally, the proposed language fails to recognize the array of needs across the continuum of long-term services and supports. Specifically, as drafted, the rule appears to imply that services may only be delivered in a home or in a small residential setting. Such options may not be desirable to or appropriate for many individuals participating in a waiver program. Additionally, such arrangements may not be feasible in rural, frontier or wilderness regions of states. NASUAD and NAMD recommend that CMS take these potential consequences into consideration and incorporate language in the final regulation that addresses these concerns.

Section 441.301(b)(1)(iv)(A) – The proposed section (b)(1)(iv)(A) states that a setting is not an integrated community setting if it is “located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment or custodial care.” The term “custodial care” is not defined in the proposed regulation, and the definition could have a significant impact on the settings where individuals may receive HCBS services. CMS should clarify if the term custodial care in this section refers to inpatient institutional custodial care. Custodial care, as defined in the Medicare Manual, Chapter 16, section 110, states “Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel”...“Institutional care that is below the level of care covered in a SNF is custodial care.” If the language above is the working definition, it should be clarified in the proposed regulations. NASUAD and NAMD recommend that CMS define and clarify the term “custodial care” for the purposes of this proposed regulation.

Section 441.301(b)(1)(iv)(A) - The term “disability-specific housing complex” is not defined. Memory care residences specifically designed for individuals with Alzheimer’s or dementia do not appear to be permissible under the proposed regulations. Such residences offer specific services to support a population that can be served in the community, but also require staff that are trained specifically in memory and dementia care. Prohibiting any disability-specific housing complex could result in the relocation of individuals with memory care needs back into institutional settings. The term may also preclude the provision of HCBS in any building immediately adjacent to or on the grounds of Section 202 (Supportive Housing for the Elderly) or Section 811 (Supportive Housing for Persons with Disabilities) housing. The phrases “on the grounds of or immediately adjacent to,” “designed expressly around an individual’s diagnosis,” or “geographically segregated from the larger community” also require clarification. CMS appears to indicate that HCBS could not be delivered near Section 202 or 811 housing which are critical housing programs. NASUAD and NAMD request that CMS define and clarify “disability-specific housing complex,” “on the grounds of or immediately adjacent to,” as well as “designed expressly around an individual’s diagnosis,” and “geographically segregated from the larger community.”

Section 441.301(b)(1)(iv)(A) - The assisted living setting clarification also could result in the involuntary relocation of a large population of individuals currently residing in Assisted Living Facilities (ALFs). ALFs may be reluctant to accept higher acuity individuals without the ability to discharge residents when the facility cannot meet the individual’s needs or that may be a danger to self or others as their care needs progress. Individuals may also be reluctant to sign long-term ALF leases. The unintended consequences of these new regulations may be more instability in the affordable assisted living marketplace and that developers will be reluctant to build new facilities at a time when affordable assisted living and/or housing with services are more important than ever due to the economic downturn. NASUAD and NAMD recommend that CMS address these potential consequences of the proposed regulation to promote stability in the assisted living marketplace.

Section 441.301(b)(1)(iv)(A) - As noted earlier, ALFs and Continuing Care Retirement Communities (CCRCs) are the preferred entry points into waiver services for many individuals that spend down to Medicaid levels. CCRCs are an entry point because of the full continuum of care offered and an option that many individuals choose. If such settings are not permissible because of certain characteristics of the setting, providers may be unwilling to accept potential Medicaid eligible individuals that would otherwise spend down to Medicaid income and resource limits, or would evict these individuals for non-payment once their resources have been spent down. Individuals facing eviction as they become eligible for Medicaid could be subject to unnecessary institutionalization, or forced into a

long-term care setting that is not of their choosing. Our Associations believe that both the home and community based setting definition and the assisted living language present serious challenges that could negatively impact people. NASUAD and NAMD strongly urge CMS to use the definition of HCBS currently in effect, strike these provisions, and convene a stakeholder working group to arrive at language that will ensure the development of, and access to, integrated homes that offer people opportunities for meaningful community connection. Furthermore, NASUAD and NAMD recommend that the dialogue begin with choice and characteristics of community connection based on personal preference rather than the building location and features.

Section 441.301(b)(6) - We commend the notion of supporting whole families and appreciate CMS' efforts to reduce administrative burden. However, the Associations have a number of concerns that, if not addressed, could impact state adoption of the new Section 1915(c) flexibility. If States choose the option of serving multiple target groups or subgroups under a single waiver, it appears that there would be a requirement to use separate assessment tools to establish levels of care, but the same service and supports planning tools for person-centered planning. While it appears the revision would create administrative efficiencies, the initial resource requirements to change the current assessment and planning tools to create a single, consistent tool, would be an obstacle for States. States that currently serve large populations under separate waivers would be at a disadvantage due to the scale and costs associated with such changes. Additionally, in the preamble, CMS notes that "through this proposed rule, we include expectations that each individual within the waiver, regardless of target group, has equal access to the services necessary to meet their unique needs." Our organizations, and other state government associations, have previously expressed concerns about CMS' quality improvement expectations. The language above, alone, presents significant challenges with designing a quality measure system and collecting related data; when coupled with CMS' current quality requirements, implementation and operation of a quality measurement system that includes elements such as 100 percent remediation becomes a significant barrier. NASUAD and NAMD request that CMS clarify quality measurement expectations in mixed population waivers.

Section 441.301(b)(6) - Program integrity is a priority for states and CMS, as federal and state partners work to be effective stewards of Medicaid funds. Medicaid requires that services link to individual Medicaid beneficiaries, not family units. In scenarios where an older parent and a child, or an older parent and an adult child with a disability, are receiving supports in the same location, such as a home, we request that CMS clarify the supports structure, service delivery expectations, and documentation expectations that demonstrate delivery of services to individual Medicaid waiver participants.

Section 441.301(b)(6) - Waivers that combine populations would require a new approach to calculating cost neutrality, for example, mixing ICF/MR with NH. The Associations request that CMS clarify how cost neutrality would be calculated for waivers that mix populations.

Section 441.304(d)(1) and (2) - Clarification of substantive changes will allow states to be more efficient in the submission of waiver amendment requests. However, limiting substantive changes to the date of CMS approval rather than the date of submission presents significant challenges when a state is under a legislative mandate to make a change and/or implement a budget initiative. While our Associations recognize the importance of providing information on any transitions that might be required when making substantive changes, we recommend that substantive changes be retroactive to the date of the waiver amendment submission date, at a minimum, for changes that have minimal impact on current participants.

Section 441.304 (e), (f)(1) and (2) - We recognize and embrace the importance of public notice. However, CMS' expectations for public notice are unclear. For example, CMS' intent appears to have different expectations for rate change public notice as opposed to public notice standards for operations and service changes. Furthermore, as with substantive changes, timeliness of proposed changes is critical. NASUAD and NAMD request that CMS clarify what is meant by public notice "be sufficient in light of the scope of the proposed changes" as well as "meaningful opportunities for input."

Section 441.304(g) - We applaud CMS' interest in creating additional options for corrective action. The Associations recommend that CMS consider formalizing current options, such as one-year renewals with external

monitoring or evaluation; conditional renewals, requiring the state to hire a monitor; and intensive CMS monitoring. However, CMS should ensure that consistent strategies are used and that timeframes and expectations are reasonable given the circumstances of the deficiency. NASUAD and NAMD request that CMS consider formalizing current options for corrective options in such a way as to ensure consistency and reasonableness.

On behalf of NASUAD and NAMD, we thank you for the opportunity to comment on this proposed rule. We look forward to continuing to work with CMS on these issues throughout this rulemaking process and beyond. If you have any questions or concerns about these submitted comments, please do not hesitate to contact Mike Cheek, NASUAD's Senior Director for State Services at mcheek@nasuad.org and Andrea Maresca, NAMD's Director of Federal Policy and Strategy at andrea.maresca@namd.us.org.

Sincerely,



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June 22, 2012

Ms. Barbara Edwards
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2249-P2
P.O. Box 8016
Baltimore, MD 21244-8016

Re: File Code CMS-2249-P2, Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice, Proposed Rule, Federal Register, May 3, 2012

Dear Ms. Edwards:

The American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL) represent nearly 11,000 non-profit and for-profit providers dedicated to continuous improvement in the delivery of professional and compassionate care for our nation's citizens who are frail, elderly, or have developmental disabilities (DD) who live in nursing facilities, assisted living residences, post-acute care centers, and homes for persons with DD. AHCA/NCAL continues to have serious concerns about the proposed definition of Medicaid home and community-based services (HCBS) settings. Below we outline those concerns and offer alternative approaches. We also offer suggestions about the needs-based criteria proposed for the 1915(i) program.

Requirements for HCBS Settings

In commenting on the previous proposed definitions of HCBS settings published by CMS for the 1915(c) and 1915(k) programs, AHCA/NCAL expressed concerns that the proposed definitions could exclude the majority of assisted living/residential care communities from the Medicaid program, thereby seriously reducing choice for most of the approximately 139,000 residents receiving Medicaid services in these settings.

We pointed out that, if the proposed definition of HCBS settings had been implemented, most of these residents would be forced to move to institutional settings and that this could significantly increase costs of their care for the federal and state governments. We note with appreciation that the revised proposed definition of HCBS settings in the 1915(i) proposed rule published May 3, 2012 responded to many of our concerns. However, several issues remain that could seriously impair the ability of assisted living/residential care facilities to participate in HCBS programs and reduce choice for beneficiaries.

Among the areas of concern we have identified in the revised definition are the following:

CMS Should Strike the "Rebuttable Presumption" That Certain Settings Are Institutional. In the proposed Section 441.656, CMS states it will impose a "rebuttable presumption that a setting is not a home and community-based setting, and will engage in heightened scrutiny, for any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or disability-specific housing complex." (pp. 26379, 26401) This wording is better than the previous version of the definition, which would have simply banned facilities in proximity to institutions or those offering services targeted to a specific disability, but it is still too restrictive and could easily eliminate many important resident-centered options for seniors and people with disabilities. In essence, it says that certain settings are guilty of being institutional before being proven innocent. Thus, it prejudices settings including assisted living units in continuing care retirement communities, Alzheimer's care facilities, and multi-level campuses. Such a presumption increases the risk of disqualification from the Medicaid program and will dampen investment in residential care facilities willing to serve Medicaid beneficiaries, which already are in short supply in most states. Further, many married couples who chose multilevel campuses could be forced to either move or be separated if they rely on Medicaid funding. AHCA/NCAL requests that the phrase "rebuttable presumption" be deleted. In fact, the entire sentence could be deleted: if a provider adheres to the other standards articulated in the proposed rule and develops a resident-centered service plan, then this sentence is unnecessary. An alternative approach would be to exempt state-licensed or registered residential care settings in which most residents are elderly from the "rebuttable presumption," as this population has different preferences and needs than younger people with disabilities.

Eviction Procedures Should Accommodate State Standards for Residential Care/Assisted Living Facilities. Another area of great concern is where the revised definition of HCBS settings lays out requirements for "provider-owned or controlled residential settings." In such settings, according to Section 441.656: "The unit or room 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 the tenants have under the landlord/tenant laws of the State, county, city, or other designated entity." (pp. 26379, 26401) Tying consumer rights to fight evictions to general landlord tenant law could create major barriers to participation in the Medicaid program for state-licensed assisted living/residential care communities. These facilities operate under state statutes and regulations that typically specify move-in, move-out procedures and include

protections for residents.ⁱⁱ Eviction standards for Medicaid HCBS settings for state-licensed facilities need to accommodate state regulations that typically establish ceilings on the level of care that can be provided in the licensed facility and that also typically do not allow a provider to keep a resident whose needs can no longer be met by the facility. It is not in the resident's best interest to remain in a facility if it does not have the capacity to provide the level of care needed. While we note with appreciation that the word "lease" has been dropped from the revised definition, we also note that pegging eviction standards to general landlord tenant law in effect resurrects an important aspect of a lease. General landlord tenant law and the use of leases are incompatible with assisted living regulatory standards in most states. An alternative approach could be to utilize appeal processes specified under state assisted living/residential care regulations.

Standards for Sharing of Units By Choice Need To Be Workable and Realistic About Economic Constraints. AHCA/NCAL has concerns about whether the proposed definition in Section 441.656 includes enough flexibility so that residents can share rooms. The revised definition says that "(I)ndividuals share units only at the individual's choice." (pp. 26379, 26401) Medicaid does not pay for room and board in HCBS settings and sharing units is often the only way that states can manage to provide Medicaid coverage for services in assisted living settings. Among the states that offered assisted living Medicaid coverage, 40 allowed units to be shared and 24 allowed sharing by choice of the residents, according to research published in 2009.ⁱⁱⁱ Resident choice in this context typically does not mean that a resident can simply refuse all possible candidates that could potentially share a room or apartment until they end up having a private unit by default. The concept of choice needs to acknowledge the economic realities of often highly limited funding available for room and board and should be reasonable. Where states provide only enough funding for shared rooms, then there should be a process, reasonable to all those involved, through which a resident can exercise choice in selecting the best person with whom to share a unit. If the federal government were concurrently offering a funding stream to finance private rooms for residents receiving Medicaid services, then a stricter standard might be appropriate.

Additional Concerns About the Proposed HCBS Settings Definition:

- AHCA/NCAL supports basing the HCBS standards on the person-centered service plan and finds that most of the general qualities laid out at the beginning of the revised definition would not present problems for assisted living/residential care communities. We have some concerns, however, that the requirement in Section 441.656 to be able to "receive services in the community, in the same manner as individuals without disabilities" (pp. 26379, 26401) could create a serious issue if interpreted strictly. This standard needs to recognize that state-licensed facilities can only provide services as allowed under state regulations. Also, while many residents contract with third parties to receive services, assisted living providers may object to certain providers coming onto their premises, especially in instances where the third party provider has a history of poor service or a criminal record. Knowingly allowing such individuals to have access to residents could create legal liability for the facility.
- On p. 26379, CMS solicits comments on two criteria that were not included in the proposed rule. The first "is related to the proposed requirement that in a provider-

owned or controlled residential setting, any modification of the conditions must be supported by specific assessed needs and documented in the person-centered service plan.” First, we are encouraged by the flexibility apparent here in that “conditions” for settings can be modified based on the service plan and needs of the resident. However, we have some concern that the documentation requirements for such modifications could become burdensome or costly. Depending on state regulations, service plans are typically updated every quarter, six months, and/or upon significant change in a person’s condition or needs.

- CMS also solicits comment on “a second criterion that would include a requirement that receipt of any particular service or support cannot be a condition for living in the unit.” While this makes sense as a general principle, for state-licensed assisted living/residential care facilities and service providers, there should be an exception for situations where the health or safety of the resident, other residents, or staff is at risk. For example, for some residents with dementia, there is a high risk of elopement and/or injury unless they have a relatively high degree of supervision. Without such services, they may not be able to live safely in the unit.

Issues Concerning Needs-Based Criteria

CMS Should Clarify How States Must Ensure People Are Able To Move from a Needs-Based Criteria Benefits Package to Benefits that Require a Level of Care. Participation in Section 1915(i) does not require an individual to meet the criteria for an institutional level of care (LOC). Furthermore, CMS notes that, due to this element of the authority, “there is no authority to apply the standard that the ‘other services’ defined and provided through state plan HCBS be necessary to prevent institutionalization.” In the proposed Section 441.677, CMS describes state responsibilities including assessment of needed services. AHCA/NCAL strongly recommends that CMS add language to Section 441.677 describing the process states must follow to monitor for changes in service and support needs which might result in the need for services associated with an institutional level of care. Specifically, CMS should provide guidance to states on how they will monitor for unexpected changes in services and supports needs and provide guidance on time lines and processes for conducting a level of care assessment as well as for enrolling individuals in a program or benefit that requires a level of care that will best meet their needs.

CMS Should Clarify That At Least 60 Days Public Notice Is Required for All Changes in Needs-Based Criteria As Well As Any Related Level of Care Changes. Changes in the needs-based criteria and any related changes in levels of care will have significant implications for people and their families. In Section 441.659(c), CMS notes that states may adjust the needs-based criteria and make related changes in levels of care without any prior approval from the Secretary. In this section, CMS indicates that states must provide for at least “60 days’ notice to the Secretary, the public, and [CMS] would propose to require, each enrollee.” AHCA/NCAL urges CMS to apply the 60-day notice standard to implementation of a Section 1915(i) program as well as any subsequent changes to the needs-based criteria *and* related levels of care. Additionally, we strongly agree with CMS’ proposal to notify each program participant. However, we suggest that

CMS clarify that both 1915(i) participants as well as people using programs and benefits that require a level of care receive 60 days notification of changes as applicable. Finally, CMS should include guidance for states on participant appeals rights and stipulate that appeals information must be included in participant communications.

Concluding Comments

AHCA/NCAL appreciates the opportunity to comment again on the revised proposed definition of Medicaid HCBS settings as well as revisions to the 1915(i) program. We greatly appreciate the work that CMS has done in changing the proposed definition in response to previous public comments. However, we still have serious concerns with the new proposed language and its potential to eliminate important choices of settings for America's seniors. This is especially the case for elderly Medicaid beneficiaries who often have a preference for living in proximity to health care facilities since many multiple health conditions along with long term care needs. Given the strong response to the 1915(c) and 1915(k) proposed rules published last year, it is especially important to gather additional comment and refine the definition further before finalizing it. While we agree that it is extremely important to ensure that HCBS settings offer resident-centered services and are integrated into the community, it also is important to make sure that Medicaid beneficiaries enjoy a wide variety of choices and are not forced into institutional settings. This could well be the outcome for tens of thousands of seniors and people with disabilities if assisted living/residential care settings are eliminated from Medicaid.

Sincerely,



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National Center for Assisted Living



Mike Cheek
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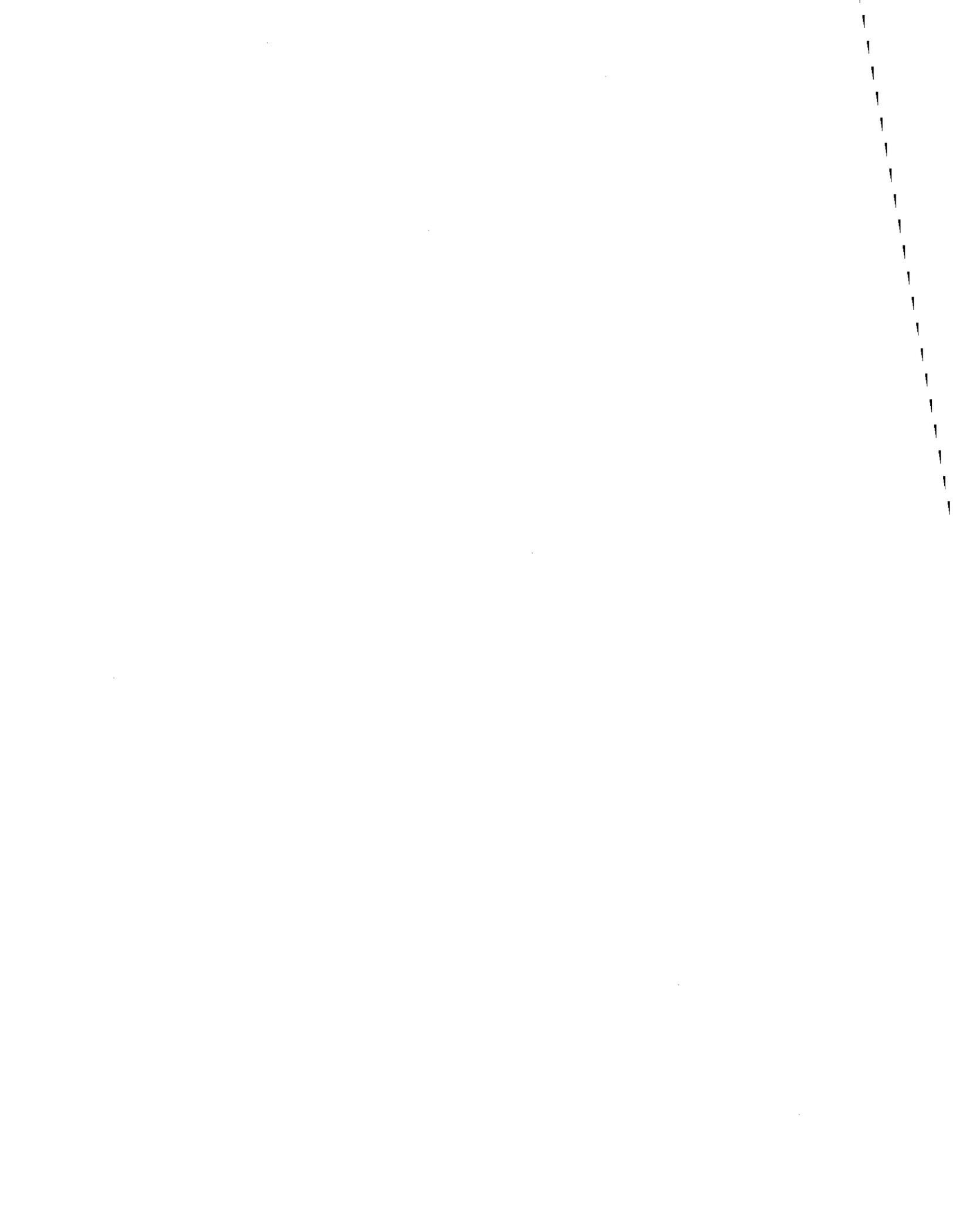
ⁱ According to a 2009 National Center for Health Statistics survey of assisted living/resident care facilities and residents, 19 percent of residents received Medicaid long term care services and 43 percent of facilities had at least one resident receiving Medicaid services. See: "Residents Living in Residential Care Facilities: United States, 2010," Christine Caffrey, Manisha Sengupta, Eunice Park-Lee, Abigail Moss, Emily Rosenoff, and Lauren Harris-Kojetin, NCHS Data Brief No. 91, April 2012, U.S. Dept. of Health and Human Services.

ⁱⁱ For a summary of state assisted living regulations, see "Assisted Living State Regulatory Review 2012," National Center for Assisted Living, Washington, D.C., 2012. The report and analysis of assisted living/residential care regulatory trends is available at www.ncal.org.

ⁱⁱⁱ "State Medicaid Reimbursement Policies and Practices in Assisted Living," Robert Mollica, National Center for Assisted Living, Washington, D.C., October 2009. Information for the report was obtained from two primary sources. Baseline information on state assisted living reimbursement policies and practices was obtained from previous studies sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Policy and Evaluation, and RTI International in 2002, 2004, and 2007. The information was updated through an electronic survey and telephone calls with state officials responsible for managing Medicaid services in licensed assisted living/residential care settings. Information was also obtained from state websites when available. Responses were received from 45 states and the District of Columbia. Information for states that did not respond to the survey was obtained from previous reports and material found on state web sites. Data were collected between March and June 2009. To obtain a copy of the report, see www.ncal.org.

Major Challenges and Possible Solutions

Challenge	Possible Solution
Private Rooms	If private rooms are a requirement due to Olmstead, CMS should allow states and providers adequate time to develop a rate structure which will support such arrangements in Medicaid. CMS must provide guidance on a transparent rate development approach
Dementia Supports	Respecting the rights of all ages and abilities, dementia care specialty unit supports should be available as requested by the individual, family or other legal guardian
Multi-Level Campuses and Presumption	If the rule still contains presumption, CMS should offer waivers of the provision or extended compliance periods to states and providers in challenging circumstances such as rural areas with limited services and supports capacity
State and Provider Capacity to Comply	The rule should include streamline the process for presumption to ease state and provider administrative burden and should offer a multi-year glide path to compliance
Eviction Procedures/Lease	Recommend utilizing appeal processes specified under state assisted living/residential care regulations



Medicaid-Financed Assisted Living – A Snapshot

- 31,100 facilities house 733,200 residents according to NCHS.
- 19% of those residents are on Medicaid and 43% of facilities have at least one resident receiving Medicaid LTC services, according to the NCHS 2010 survey of residential care places.
- Alzheimer's disease/dementia is the second most common condition among assisted living residents with 42% of residents having the condition. NCHS also found that 48 % experience confusion.
- 38% of residents need help with 3-5 activities of daily living.
- At least 40 states allow shared units. According to the National Academy for State Health Policy, 45.5% of Medicaid residents in assisted living reside in rooms designed for two or more persons.
- The average age of an assisted living resident is 86.9 years according to the 2009 Survey of Assisted Living. The average age at move-in is 84.6. Three out of four assisted living residents are women.
- There are currently more than 41,400,000 people in the U.S. age 65 and over, but that number is dwarfed by the 82,800,000 in the 45 to 65 age bracket who will need aging housing and services. In 2010, 40 percent of the U.S. population were age 45 and over. To compound the number of aging individuals, one in three working Americans has no retirement savings other than Social Security and 35% over the age of 65 rely almost entirely on Social Security alone. In the future more older adults will turn to Medicaid and Medicaid-financed assisted living for supports.

