JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

January 9, 2017

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–2404–NC
P.O. Box 8013
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Submitted electronically

Re: CMS–2404–NC; RIN 0938–ZB33
RFI: Federal Government Interventions to Ensure the Provision of Timely and Quality Home and Community Based Services

Justice in Aging is pleased to submit comments in response to the above referenced Request for Information (RFI), published at 81 Fed. Reg. 78,760 (Nov. 9, 2016).

Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Our comments are informed by our work with advocates across the country on issues related to the provision of home and community-based services (HCBS) for low-income older adults, both in fee-for-service Medicaid and through Medicaid managed care.

We appreciate the significant strides CMS has made to promote community integration for older adults and persons with disabilities. Expansion of HCBS options – including the Money Follows the Person (MFP) Program, 1915(i) HCBS State Plan Option, 1915(k) Community First Choice (CFC) Option, Balancing Incentive Program, and options for self-direction – have greatly increased the numbers of people able to live in their own homes and communities instead of institutions. Equally important, the 2014 HCBS Settings Rule helps ensure that persons receiving HCBS can truly experience the benefits of community life. Moreover, the Americans with Disabilities Act's promise of community access and integration for all is closer than ever, and it is important that CMS continues to help states move forward without delay.

We applaud CMS's recognition that there is much more the agency can and must do to ensure the provision of timely and quality HCBS. As noted in the RFI, the voluntary nature of Medicaid HCBS options has resulted in significant differences in the availability of HCBS by population and state, with far too many people being isolated in institutions and other segregated settings due to inadequate access.

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Our comments follow, organized under the questions posed by CMS in the RFI.

A. What are the additional reforms that CMS can take to accelerate the progress of access to HCBS and achieve an appropriate balance of HCBS and institutional services in the Medicaid long-term services and supports (LTSS) system to meet the needs and preferences of beneficiaries?

Require States to Provide HCBS. One of the biggest barriers to ensuring that all people who can and want to live in the community have access to HCBS is the fact that states must provide institutional services to eligible individuals, but HCBS is optional. Over 500,000 people are on waitlists for HCBS waivers: these are persons who choose to wait for HCBS despite the fact that they could access institutional services immediately. We recommend that CMS develop a pilot program and/or work with states to develop programs that would offer HCBS to any individual prior to admission to an institutional setting, like the "Pilot Comprehensive Long-Term Care State Plan Option" proposed in the President's Budget.

Require Spousal Impoverishment Protections for HCBS Beneficiaries. Spousal impoverishment protections have been mandatory for institution residents, but provided at a state's option for persons receiving Medicaid HCBS. Currently, however, under section 2404 of the Affordable Care Act, persons receiving HCBS also are entitled to those spousal impoverishment protections. This mandatory application of spousal impoverishment protections is effective during the five-year period concluding at the end of 2018.

Spousal impoverishment protections are important for both institution residents and for persons receiving HCBS. No person should be forced to move into an institution into order to access spousal impoverishment protections, when he or she could be receiving adequate assistance at home. We accordingly recommend that CMS take all available steps to make spousal impoverishment protections available to HCBS beneficiaries, at least to the extent those protections are available to nursing facility residents.

Authorize Retroactive Coverage for HCBS. Current CMS policy incentivizes institutional care over HCBS by offering retroactive coverage of the former but not the latter. Assume that a nursing facility resident spends her savings below the Medicaid eligibility threshold on January 1, applies for coverage on April 1, and has a care plan approved on April 15. Under these facts, she can receive Medicaid coverage retroactive to January 1 — three months prior to the month of application. If, however, the same woman lives in an assisted living facility, and applies for coverage through a Medicaid HCBS program, her coverage will not begin until April 15. CMS policy requires that HCBS coverage be prospective-only from the date on which a service plan is approved.[1] This policy was unsuccessfully challenged in recent litigation against the State of Ohio, and CMS defended its policy through an amicus brief and oral argument.[2]

This CMS policy applies to all HCBS, whether services are provided in a private home, a residential facility, or other setting. In each of these settings, the policy harms consumers and perversely encourages persons to choose institutional care. When HCBS are provided but not covered, Medicaid

[1] *See, e.g.*, CMS, Instructions, Technical Guide and Review Criteria, Application for a 1915(c) Home and Community-Based Waiver, at 46 (Jan. 2015).
[2] *See Price v. Medicaid Dir.*, 838 F.3d 739 (6th Cir. 2016).

beneficiaries are saddled with unaffordable bills. Furthermore, services often are delayed until the service plan is approved, because a provider will not initiate services until coverage is assured. Such delay can have negative health consequences, and frequently forces the person to enter an institution in order to receive immediate care.

We urge CMS to issue guidance that would eliminate this inappropriate bias towards institutional care. We recommend that CMS policy be revised to authorize HCBS coverage up to three months prior to the month of application, if eligibility standards otherwise are met and services are consistent with the subsequently-developed service plan. This recommended change would benefit both Medicaid beneficiaries and state Medicaid programs.

Improve Income Deductions to Allow a Beneficiary to Retain a Home Through a Short Institutional Stay. Too frequently, Medicaid beneficiaries lose their homes due to a relatively short institutional stay. Current Medicaid regulations address this problem but in an inadequate way. The regulations give states an option to provide an income deduction for housing expenses when a physician has certified that the beneficiary will be able to return home within six months. *See* 42 C.F.R. §§ 435.725(d), 435.733(d), 435.832(d).

We recommend two changes. First, such deductions should be mandatory rather than optional. Second, CMS should ensure that the deductions are sufficient. Currently, many states cap deductions at levels that are far short of a beneficiary's costs to maintain a house or apartment.

Provide Additional Resources for Transitions from an Institution to an HCBS Setting. Medicaid beneficiaries face numerous difficulties when seeking to transfer back to an HCBS setting after an extended stay in a nursing facility or other institution. Under the Money Follows the Person (MFP) program, 43 states (plus the District of Columbia) received additional Medicaid funding to facilitate transitions, so that beneficiaries are not trapped unnecessarily in institutional settings. MFP programs successfully facilitated transfers from institutions for tens of thousands of persons. Unfortunately, MFP was a time-limited program, and its statutory authority expired in 2016. In the absence of additional statutory authority for an MFP-type program, we recommend that CMS take all possible steps to provide transition assistance through existing HCBS authorities.

Continue and Expand Medicaid Authorities that Incentivize HCBS. Over the last decade, states have been given the option of participating in Medicaid authorities that help them expand their HCBS programs, including the Money Follows the Person (MFP) program, the 1915(i) HCBS State Plan Option, the 1915(k) Community First Choice (CFC) Option, and the Balancing Incentive Program. We recommend that CMS work with Congress to re-authorize and fund the successful MFP program. MFP provides assistance, support and funding to assist older adults and persons with disabilities in transitioning from institutions to their own homes or a community residence. Since 2005, the program has assisted more than 51,000 people to move out of institutions and has proven to be a critical strategy for states to expand their HCBS programs.

We also recommend that CMS work with Congress to re-authorize the successful Balancing Incentive Program, which incentivized states heavily invested in institutional services to rebalance towards investment in HCBS. This program was instrumental in assisting certain states to greatly improve and expand their HCBS programs.

Likewise, we recommend that CMS take steps to facilitate states' use of the 1915(i) HCBS State Plan Option. CMS should provide technical assistance to states about the 1915(i) authorities, similar to recent CMS guidance on 1915(k) programs. In addition, we support the proposals in the President's Budget to expand eligibility for 1915(i) and (k) programs.

Address the Lack of Affordable, Integrated Housing. The lack of affordable housing is one of the primary causes for Medicaid beneficiaries remaining "stuck" in institutional settings. Medicaid has an institutional bias related to housing costs – Medicaid covers room and board in an institutional setting but cannot pay for rent in the community. We recommend that CMS create a demonstration to use cost-savings to provide rental subsidies to HCBS participants who could not otherwise afford to live in the community. Also, CMS should work together with the Department of Housing and Urban Development (HUD) to expand access to affordable housing for Medicaid beneficiaries who need HCBS, particularly those persons are in or at risk of entering institutional settings.

Comments on Select Specific Sub-Issues under (A):

1. *Possible Change in Applying Definition of "Nursing Facility."*

Do Not Deny Nursing Facility Care to Those Persons Whose Needs Are Determined to Be Addressable By HCBS. CMS suggests that "the statutory nursing facility service definition could provide a basis for states to offer the mandatory nursing facility benefit only to individuals eligible for nursing facility coverage whose assessed need cannot be met by HCBS." RFI, 81 Fed. Reg. at 78,767. We recommend that CMS not change current policy in this area, and that CMS and state Medicaid programs continue to offer a choice of nursing facility care or HCBS to persons who have nursing-facility-level care needs.

CMS's suggested change would confuse and potentially limit eligibility for HCBS. HCBS eligibility generally is predicated on the person requiring nursing-facility-level care but for the availability of HCBS. CMS's suggested change might limit the scope of nursing-facility-level care, and thus also limit HCBS availability.

Most importantly, CMS's suggested change would deprive Medicaid beneficiaries of the choice that they currently possess. When a Medicaid beneficiary has been determined to need nursing-facility-level care, he or she is in the best position to determine whether to receive that care in a private home, an HCBS-funded congregate living setting, or a nursing facility. This is a personal choice, and cannot and should not be converted into a binding administrative determination. CMS is considering a system in which a state (or a managed care organization) would determine whether the beneficiary's needs could be met through HCBS. If it were determined that the person's needs could be met by HCBS, nursing facility care would be denied. Or, if it were determined that the person's needs could not be met by HCBS, then HCBS would be denied.

By requiring an official determination of whether HCBS is feasible, CMS's suggested change would convert a personal choice into an administrative action, and inevitably would lead to frequent administrative appeals. We support HCBS, but recognize that HCBS works best when the Medicaid beneficiary has affirmatively chosen HCBS over institutional care. HCBS should remain as a choice for beneficiaries, rather than having an administrative determination that assigns a beneficiary to either HCBS or institutional care.

2. *Benefit Redesign.*

Develop HCBS Programs that Offer Eligibility Prior to the Person Needing Institutional Care. CMS should continue to advance options, such as Section 1915(i) programs, that allow for HCBS services before the beneficiary's needs have risen to the institutional level of care. HCBS as a preventive measure is desirable for beneficiaries as well as being cost-effective. Earlier provision of services can help prevent beneficiaries from developing higher-intensity and more expensive care needs, including potentially avoidable inpatient admissions and emergency room visits.

B. What actions can CMS take, independently or in partnership with states and stakeholders, to ensure quality of HCBS including beneficiary health and safety?

Establish Common HCBS Quality Measures that Examine Integration, Health and Safety, and Consumer Satisfaction. CMS should continue its efforts to establish common quality measures for HCBS. We believe quality measures must look at a broad array of outcomes that are important in a person's life, including health and safety, community integration, self-determination and choice, and consumer satisfaction. We recommend that CMS work with ACL and DOJ to identify effective HCBS quality measures based on DOJ's *Olmstead* enforcement work and ACL's work around person-centered planning.[3] We recommend, among others, standards from the National Core Indicators Survey, and the National Quality Forum.

Require States to Set More Specific Standards for Beneficiary Health and Safety and Increase CMS Monitoring: Ensuring that states have in place effective strategies to ensure the health and safety of HCBS participants is critical. The assurances that states are currently required to provide to CMS, including in appendix G of the 1915(c) waiver application, are too high-level and do not receive detailed enough scrutiny from CMS during the waiver application review process. This has been borne out in multiple state reviews where the HHS Office of the Inspector General has documented that that the assurances on health and safety made in the application have not in fact been implemented by states. We recommend that CMS develop a common set of specific health and safety elements that must be included in state HCBS monitoring processes. CMS should require that states regularly document that these health and safety requirements are being effectively implemented. States, at a minimum, should have each of the following:

- *Real-time critical incident reporting systems* with clear definitions of "critical incidents" and criteria for "serious risk" of "critical incidents." These systems should be managed by an entity independent of providers, and should require regular training of providers in using the system.
- *Systems to promptly report, investigate, and address abuse, neglect and serious harm*, with clear rules on mandatory reporting. Such systems should have clear criteria for when cases are referred for criminal investigation.
- *Mortality review systems* that report all unexpected deaths to an independent entity based on clearly defined standards of "unexpected" deaths. The system should provide for a preliminary investigation to identify any suspicious circumstances, and a full investigation (including interviews with staff, review of records, and autopsy reports) when suspicious circumstances are present.

[3] For more information regarding rebalancing measures, see *Is It Working? Rebalancing Measures in Dual Eligible Demonstrations and MLTSS Waivers*, available at: http://dualsdemoadvocacy.org/wp-content/uploads/2014/01/Rebalancing-in-MLTSS-and-Dual-Eligible-Demo_01.13.14.pdf.

- *Data collection systems* to aggregate data to identify systemic issues, and issues with particular providers.

Enforce Requirements Against State Medicaid Programs. CMS should promptly address any evidence of state violations of health and safety assurances. CMS should play an active role in working with states to develop Corrective Action Plans (CAPs) using best practices from other states. CMS should require that states' CAP process is transparent to the public and that states engage stakeholders in CAP development and implementation, including considering how to leverage external monitoring by Protection and Advocacy organizations and Long Term Care Ombudsman programs.

Increase Transparency. Currently, HCBS quality is extremely difficult for stakeholders to evaluate, since the relevant data generally is not publicly available. CMS should revise its policies to provide for broad availability of HCBS quality monitoring data. Nursing facility data is broadly available on Medicare's Nursing Home Compare website, and there is no reason why HCBS data should not be similarly available, whether to evaluate the state's HCBS system broadly, or the performance of particular HCBS providers.

Ensure that All HCBS Settings Provide the Benefits of Community Living. We strongly supports the HCBS Settings Rule. The Rule is a culmination of multiple rule-making processes and the input of thousands of stakeholders, reflecting decades of advancements in providing older adults and people with disabilities access to the community. We recommend that CMS continue providing technical assistance to states on successful implementation of the Rule. Also, we urge CMS to maintain the Rule's strong standards for CMS's evaluation of "presumptively institutional" settings through the Rule's "heightened scrutiny" process. Only settings that provide meaningful community integration and access should be eligible for HCB funding. Implementation and ongoing monitoring of the Rule should be seen as a critical component of CMS's quality efforts.

C. What program integrity safeguards should states have in place to ensure beneficiary safety and reduce fraud, waste and abuse in HCBS?

Use Financial Management Services to Assist Consumers and Ensure Program Integrity. We understand that HHS' Office of the Inspector General has raised concerns about program integrity in personal care programs. We believe that Financial Management Services (FMS) in self-direction are an important tool to offer robust individual choice and control while supporting financial integrity. FMS entities ensure that workers are paid in compliance with tax and labor law and that payments are made on participants' behalf only when the expenditure is approved in the individual's budget, allocation or plan of care. We applaud CMS's requirement of FMS in Medicaid waivers with self-direction.

Applied Self Direction, the new home of the National Resource Center for Participant-Directed Services, has identified key practices in FMS that effectively prevent and detect fraud in self direction. By requiring particular functions from FMS in self-direction, states and MCOs can ensure programs with limited fraud and high levels of participant choice and control. We encourage CMS to develop incentives or standards for states and MCOs to establish key FMS controls aimed at detecting and preventing fraud in self-direction.

D. What specific steps could CMS take to strengthen the HCBS home care workforce?

Ensure Adequate Rates. The lack of competitive wages and benefits for direct care and personal care workers is creating a significant crisis in many states' HCBS systems. Provider agencies report huge turnover and vacancy rates, which limits access and creates unsafe situations due to insufficient staffing. In some cases, providers are closing their doors completely.

We recommend that CMS revise the Medicaid access regulations to explicitly consider long-term services and supports, and to include waiver and demonstration programs. We also recommend that CMS use the waiver approval and renewal process to work with states to ensure sufficient capacity for needed services, particularly for people with complex and/or significant support needs.

Expand Self-Direction as a Strategy to Address Workforce Shortages. Self-direction has proven effective at tapping an otherwise unrepresented labor pool in the home health workforce. Self-directing persons do not have to rely on agency home care workers and instead often hire friends and family, who may be interested in the job due to the personal relationship with the person needing assistance. A study has shown that self-directing participants are more likely to receive assistance, due to their better ability to navigate limited labor markets.[4] Also, self-direction can lead to better pay rates, since lessened overhead (compared to agencies) allows a greater percentage of funding to go towards the direct-care workers.

We recommend that CMS work with states, MCOs and stakeholders to ensure that self-directing individuals are able to tap into the workforce of friends and family members. Self-direction has repeatedly shown that these worker relationships produce quality outcomes, and this approach strengthens the labor supply.

Promote Cultural Competence. The quality of personal care depends significantly on personal relationships and communication. CMS and state Medicaid programs should make every effort to promote cultural competence among workers, including the ability to speak the principal language of program participants, and emphasis on respect and understanding of the participant's culture.

Thank you for the opportunity to comment. If you need additional information, please do not hesitate to contact me at JGoldberg@justiceinaging.org. We look forward to continuing our work with you on improving HCBS quality and availability.

Sincerely,

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[4] Kathryn Kietzman & A.E. Benjamin, *Who's in Charge? A Review of Participant Direction in Long-Term Care*, Public Policy Aging Report, Vol. 26, No. 4, 118-22 (2016).