



Advocacy. Action. Answers on Aging.

June 14, 2011

Dr. Donald Berwick
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2296-P
P.O. Box 8016
Baltimore, MD 21244-1850

Dear Administrator Berwick:

The following comments by the National Association of Area Agencies on Aging (n4a) are in response to the notice of proposed rulemaking on the 1915(c) Medicaid home and community-based waiver program (CMS-2296-P) posted in the Federal Register on April 15, 2011. n4a is the leading voice on aging issues for Area Agencies on Aging (AAAs) and a champion for Title VI Native American aging programs. Through advocacy, training and technical assistance, we support the national network of 629 AAAs and 246 Title VI aging programs. We appreciate the opportunity to comment and participate in the continued process for considering these proposed regulations and developing criteria for home and community standards.

1. Target Groups

We support CMS's proposal that would allow states to design waiver programs that serve more than one target population group and to provide waiver services based on need, rather than diagnosis or condition. We agree that this added flexibility would remove existing barriers to person-centered, needs-based service delivery methods and help break down funding silos. Further, we also agree that states should have the option of combining target groups in one waiver, or choosing to offer waiver services to groups defined differently than pre-defined targeting groups. We believe that states should have ability to submit a coordinated waiver that combines targets groups, or keep them separate, as in the past.

It is imperative that any consolidated waivers do not marginalize the needs of any target group currently being served or reduce a state's ability to serve under-served populations. If a state chooses to combine population groups under one waiver program, it must also be able to meet the particular needs of each of the target groups. As such, we strongly support the proposal in 441.302(a)(4) to require an assurance "that the State is able to meet the unique service needs that particular target groups may present when the State selects to serve more than one target group under a

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single waiver.” It also important to consider how any newly formed waiver programs serving dual target populations, such as “aged and individuals with intellectual/developmental disabilities,” would be administered by state Medicaid programs and who would assume primary responsibility for the combined waiver program. However, overall, we believe this could an opportunity for developing stronger partnerships at the state level between aging and disability agencies.

2. Home and Community-Based Service (HCBS) Settings

We appreciate CMS’s recognition that home and community settings be the least restrictive as possible and are characterized by a home-like environment tailored to the individual needs of consumers, as opposed to provider-centered and institutional living arrangements. In our initial comments during the ANPRM, we expressed concern that if the proposed definition of home and community was *too* restrictive it could reduce the number of housing options available to older adults and people with disabilities receiving waiver services. We noted that criteria that would prevent waiver clients from receiving services in an assisted living facility or a low-income housing community would limit choice for older adults—especially where other housing options may be already limited, such as in rural areas.

We remain concerned about establishing regulations that are overly prescriptive in specifying criteria for community living standards. Individuals might live in a wide variety of settings and we fear that the development of criteria that is too prescriptive may result in needy individuals being found ineligible solely due to where they live. The preamble to the proposed regulations sets out a number of conditions for assisted living settings to be considered home and community-based settings. We believe these conditions are applicable to not only assisted living but more broadly to home and community-based settings and should be incorporated into the proposed regulations. However, there is a need for further clarification on this point due to the current variation in how assisted living is defined at the state level. While there is merit in establishing general parameters for what constitutes a home and community-based setting, we believe that the regulations as proposed in subsection (b)(1)(iv) (A) and (B) could possibly lead to the unintended negative consequence of reducing access to HCBS.

For example, CMS has proposed forbidding the use of Medicaid funding if the setting is also a “facility that provides inpatient institutional treatment or custodial care.” These terms are not defined in the proposed regulation, and this ambiguity could have a significant impact on the settings where individuals may receive services. Custodial care has been defined in the Medicare Benefit Policy Manual as care that “serves to assist an individual in the activities of daily living.” This type of assistance is commonly provided to individuals receiving Medicaid services in array of home and community-based settings. We are very concerned that these terms could potentially preclude individuals who live in any building that provides assistance with daily activities from receiving Medicaid HCBS. This could encompass a variety of residential settings where HCBS are regularly provided, including assisted living facilities, independent living facilities, continuing care retirement communities, and Section 202 Housing for the Elderly or Section 811 Housing for Persons with Disabilities.

3. Person-Centered Planning

As previously articulated during the ANPRM, we support CMS’s desire for a person-centered planning process, but we believe that the consumer has the right to choose if they would like to self-direct their plan of care. Person-centered planning and self-directed care should be the choice of the consumer to make, not a federal mandate. For some individuals, this requirement would not be helpful in securing needed services. As such, we support CMS’s intention to assure that individuals served by waivers targeting a broad range of conditions receive individualized care by including the requirement that the service planning process be person-centered and the services specified in the plan of care be based upon the needs of the individual. We support the addition of regulatory language to the person-centered planning process, consistent with the recently proposed Community-First Choice Option regulatory provisions, that would require that the process be timely, that the plan “ensure...the services and supports meet the individual’s needs,” and that a plan be signed and “agreed to by the individual.”

4. Effective Date of Waiver Amendments and Public Input Process

We support the proposal to prohibit retroactive approval of substantive changes to HCBS waivers, and to require that a state demonstrate how it will ensure smooth transitions and minimal disruption of service or adverse impact of a change on beneficiaries. We also strongly support the proposal to require states to use a “public input process” for waiver modifications, as it is essential that stakeholders have input into waiver development and changes that could affect them as consumers. Furthermore, the public input process must be accessible to the public—especially including older adults and people with disabilities. States must take significant steps to ensure that people who want to participate have the opportunity to do so, such as publicizing the opportunity for input and ensuring that there is adequate time to share input in person and through other mediums.

5. Ensuring State Compliance

We are generally supportive of the proposal to provide CMS with additional procedures to ensure state compliance with waiver requirements. However, we are concerned that the first strategy to ensure compliance is the imposition of a moratorium on waiver enrollments. Unfortunately, this strategy would have more of a negative effect on prospective waiver participants than it would lead to corrective action by the state Medicaid agency. We suggest removing the moratorium, so that the primary sanction would be the withholding of a portion of Federal payment for waiver services until the state is in compliance.

We appreciate CMS’s efforts to make the 1915(c) waiver process more flexible for states and more consumer-friendly, and we look forward to continuing to work with CMS and provide input as these proposed regulations are further refined.

Sincerely,

A handwritten signature in cursive script that reads "Sandy Markwood". The signature is written in dark ink and is positioned above the printed name and title.

Sandy Markwood
Chief Executive Officer