

National Senior Citizens Law Center



3435 Wilshire Blvd., Suite 2860 • Los Angeles, CA 90010 • 213-639-0930 • Fax: 213-639-0934 • www.nsclc.org

August 20, 2009

Ms. Charlene Frizzera
Acting Administrator
Center for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave S.W.
Room 445-G
Washington, D.C. 20201

**RE: File Code CMS-2296-ANPRM
Comments on Advance Notice of Proposed Rulemaking
Medicaid Program: Home and Community-Based Services (HCBS) Waivers
RIN 0938-AP61**

Dear Ms. Frizzera:

The National Senior Citizens Law Center (NSCLC) writes to comment on the Advance Notice of Proposed Rulemaking relating to Medicaid home and community-based services (HCBS) waivers. Our comments focus on the CMS proposal to amend the regulations at 42 CFR subpart G as applicable to waiver beneficiaries receiving services in residential care facilities such as assisted living facilities.

NSCLC is a public interest law firm which, since 1972, has advocated before the courts, Congress and federal agencies to promote the independence and well-being of low-income elderly and disabled Americans. Because of the critical support the Medicaid program has provided to low-income elderly and disabled Americans, NSCLC has maintained a historical focus on Medicaid, especially on Medicaid's HCBS coverage for persons with chronic conditions. This issue has a particular relevance for us currently, as we are completing a comprehensive national study on state policies in the provision of Medicaid HCBS waiver services to assisted living facility residents.

NSCLC Supports Federal Standards, Not Mere Policy Guidelines, To Assure That HCBS Services Truly Are Provided In a Home-Like Setting, And That Residents Receive Adequate Care.

We are pleased that CMS will require standards for the home and community-based nature of settings in which Medicaid beneficiaries receive waiver services. Institutions such as nursing

facilities have historically hampered residents' ability to maintain their independence, and so HCBS funding has been important in offering an alternative to nursing facility care. It should not be enough, however, for purposes of federal Medicaid reimbursement and the states' obligations under the Americans with Disabilities Act, that Medicaid beneficiaries live in settings other than nursing facilities or hospitals. We agree with CMS that the absence of home and community standards for residential care settings has allowed such entities to impose provider-centered and institutional-like environments. With this in mind, we make the following suggestions for the development of standards for "home and community-based" settings.

1. CMS should develop standards, rather than establishing policy guidelines for the states' development of standards.

CMS acknowledges that "home and community have not been explicitly defined, and as a consequence" some waiver beneficiaries have received care in an "institution-like living arrangement." 74 Fed. Reg. 29,453, 29,455 (2009). In other words, assisted living facilities and other waiver-funded facilities have provided services in too institutional a manner.

CMS states that it has "attempted to address this problem indirectly through our review of State service definitions for HCBS, with limited success." Despite this limited success with its current oversight of state practices, CMS states that even now it does "not contemplate specifying criteria for home and community standards in the proposed regulation," and instead will "develop policy guidelines for State definitions." Under CMS's proposal, a facility will be required to meet "standards for community living, as defined by the State and approved by the Secretary."

We respectfully suggest that CMS will be repeating past mistakes if it merely develops guidelines for the evaluation of state-developed definitions. The difficulty currently is that CMS staff is forced to individually review state service definitions, without clear federal requirements. To a great extent, the same difficulty would be present if CMS were only to develop policy guidelines, with CMS staff again responsible for making judgment calls about the appropriateness of state choices.

Instead of relying on guidelines and the discretionary judgment of state and federal officials, CMS should establish regulatory standards that assure an adequately home-like environment. This level of certainty would benefit both waiver beneficiaries and state Medicaid programs.

2. CMS standards should be consistent between HCBS waivers and the HCBS state plan option.

In the implementation of the HCBS state plan option (section 1915(i) of the Social Security Act), CMS has proposed regulations to establish "standards for community living facilities." 73 Fed. Reg. 18,676, 18,697 (2008) (proposed 42 C.F.R. § 441.556(3)). To provide consistency, and to assure that Medicaid beneficiaries receive care in a non-institutional setting under either an HCBS waiver or the HCBS state plan option, CMS should develop standards that would be equally applicable under either funding mechanism.

In the proposed regulations for the HCBS state plan option, CMS states that a setting is more likely to be considered "home or community-based" if the resident can do the following:

- Control access to, and furnish, private living quarters.
- Have visits and telephone calls with privacy.
- Have access to food and a kitchen at unscheduled times.

We agree, and suggest that these characteristics are necessary (although not sufficient) to establish a facility as non-institutional for the purposes of Medicaid HCBS reimbursement.

3. Standards for community living facilities should exempt situations in which a waiver beneficiary is living with a family member.

CMS proposes to require that “standards for community living” apply if a waiver beneficiary resides in a home “owned, leased or controlled by a provider of one or more health-related treatment or support services.” 74 Fed. Reg. at 29,455. We ask that when the regulation is drafted, care be taken to exempt from this requirement those homes where a beneficiary is living with a relative who is providing such services. Imposing standards in such situations would be inappropriate for beneficiaries and their families.

4. Standards should include requirements that a Medicaid-certified service provider make reasonable accommodations to meet a resident’s needs and preferences.

The non-institutional nature of waiver services is not dependent solely on a resident’s access to her living unit and the rest of the facility, but also depends heavily on how services are provided. CMS should establish standards to assure that waiver services are provided in a truly person-centered fashion.

These standards should assure that:

- Service planning is done in a way that fully involves the resident and/or the resident’s family member or representative, with a process that allows the resident to articulate his or her needs and preferences.
- A service provider is required to make reasonable accommodations to meet a resident’s needs and preferences. This includes, but is not limited to, accommodating a resident’s preferences regarding foods and activities.
- A resident has the right to refuse services.

5. To protect beneficiaries, CMS should develop other important standards for the provision of waiver services in a residential facility.

NSCLC is concluding a comprehensive study of Medicaid HCBS payment for assisted living. The study has a particular focus on how state Medicaid policy affects facility residents. When the findings are published later this year, the information will be broadly disseminated to CMS, state Medicaid programs, and other interested stakeholders. In the meantime, if you have an immediate interest in the findings, please contact us for draft copies of the findings, analysis, and recommendations.

National Senior Citizens Law Center

The research identified many problems for Medicaid-reimbursed residents. To protect residents, federal regulatory protections are required, including (but not limited to) the following:

- A Medicaid-certified facility should be required to accept Medicaid-reimbursement from a Medicaid-eligible resident. Today, certified facilities too frequently refuse to accept Medicaid reimbursement, causing the eviction of the Medicaid-eligible resident.
- When a Medicaid-eligible resident has been hospitalized, the resident's facility should be required to hold the resident's room for at least a week and, after a hospitalization of any length, should be required to offer readmission to the next available room. Payment for the room hold could be made by a Medicaid program under the "personal assistance retainer payments" authorized by Olmstead Update #3.
- A Medicaid-certified facility should be allowed to evict a Medicaid-eligible resident only if the resident has failed to pay, the facility is going out of business, the resident no longer requires the level of care provided under the facility's license, the resident needs a level of care that cannot be provided under the facility's license, or the resident's presence in the facility endangers the health or safety of others.
- If a resident requires a level of care that can be provided under the facility's license, the facility must provide the required level of care.
- A Medicaid-certified facility must be required to accept Medicaid reimbursement as payment in full, except for whatever payment from the resident is specified under Medicaid medically-needy spend-down or post-eligibility calculations, or under the Medicaid-designated room and board charge.

Conclusion: NSCLC wishes to participate in any stakeholder processes for developing standards or policies for home and community-based services.

Thank you for your consideration of these comments. Please feel free to contact us with any questions or suggestions that you might have. We request to be included in any stakeholder processes for the development of standards or policies.

Sincerely,

Eric Carlson, Esq.
ecarlson@nsclc.org

Gene Coffey, Esq.
gcoffey@nsclc.org