DHCS
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Director

State of California—Health and Human Services Agency
Department of Health Care Services

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June 3, 2008

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-24490-P
P.O. Box 8016
Baltimore, MD 21244-8016

COMMENTS ON PROPOSED RULE 2249-P (HOME AND COMMUNITY-BASED STATE PLAN SERVICES)

Dear Madam or Sir:

The Department of Health Care Services (DHCS), on behalf of the State of California, respectfully submits the following comments on Proposed Rule 2249-P, related to Home and Community-Based State Plan services, published in the *Federal Register* on April 4, 2008.

The State appreciates the added flexibility and option to provide services to older persons and persons with disabilities under the State Plan rather than through waivers or demonstration projects. Offering States the opportunity to provide these services to individuals who require less than institutional level of care is a progressive policy that has the potential to support many people in our communities to avoid institutional care. This is an important step to support and advance Olmstead goals, particularly diversion from facility care. While we have a strong program in California to provide Personal Care Services and many other Home and Community Based Services (HCBS) to Medi-Cal beneficiaries, and our Money Follows the Person project is embarking on transitioning 2,000 persons from nursing facilities to the community over the next few years, the 1915(i) option provides our State with a new tool that may offer opportunities to help further support our Olmstead efforts.

There are a few areas in the Proposed Rule that the State has identified as needing further clarification and guidance, particularly eligibility, managed care, and the assessment/care planning provisions. Additionally, we asked for confirmation about our understanding of the initial 1915(i) infrastructure and future amendments process. Our comments follow.

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ELIGIBILITY

We would like to request clarification on several items related to eligibility. Based upon the written Proposed Rule, California interprets the following regarding eligibility for 1915(i) services:

Under Section 1915(i) of the Act, the eligibility determinations do not change the receipt of regular medical assistance under any Medicaid program. After the eligibility determination is completed using the State's more liberal income methodologies, individuals are eligible for 1915(i) HCBS if the income does not exceed 150 percent of the federal poverty level (FPL).

Section 441.556(b) of the Proposed Rule provides States with an option that applies only to individuals who would be otherwise eligible for the Medically Needy (MN) program. We would like clarification of CMS' explanation of proposed regulation 441.556(b)(i). We are interested in the portion of the Background section of the Proposed Rule under #14 (Non-application) on page 18684 where CMS states:

> Being exempt from the requirements of section 1902(a)(10)(C)(i)(III) of the Act enables States to provide medical assistance to medically needy individuals in the community by electing to treat such individuals as if they are living in an institution for purposes of determining income and resources. This would result in the State not deeming income and resources from an ineligible spouse to an applicant or from a parent to a child with a disability.

This statement seems to imply that two separate eligibility determinations should be made for medically needy individuals seeking HCBS benefits even before the 150 percent FPL test is applied. Our basis for this is the reference to deeming "resources." If this exemption only applied to the 150 percent FPL test that is imposed after an individual is found eligible under the regular medically needy test, then there would be no need to refer to resources.

Therefore, it appears from the language in the Proposed Rule that a medically needy individual could have a high share of cost (SOC) for non-HCBS benefits, but a low or no SOC for HCBS benefits once his or her spouse's income and resources are disregarded. It also appears that a person who is ineligible for non-HCBS benefits due to resources could actually be eligible for HCBS benefits because the spouse's resources are disregarded.

We think the problem with this interpretation is that CMS has stated in the Background section on page 18678 that the DRA provision "does not create a new eligibility group. Individuals who have not been found eligible for Medicaid cannot be enrolled in the

State Plan HCBS benefit even if they otherwise meet the requirements for the benefit. In addition, individuals may not be enrolled in the State Plan benefit if their income exceeds 150% of the FPL." (Since the DRA provision says that the benefit is for "individuals eligible for medical assistance under the State Plan" we agree with CMS' interpretation that there is not a new eligibility group created by the provision).

Another logical interpretation of Section 1915(i)(3), and the one that we suggest, is that the exemption from 1902(a)(1)(C)(i)(III) only applies to the 150 percent FPL test, and does not apply to resources at all. Under that interpretation, the 150 percent FPL test should be applied after an individual has been found eligible with or without a SOC (i.e. the person passes the regular medically needy resource test and also meets the regular income test, although the person may or may not have a SOC to meet). At that point, the income should be recalculated using institutional deeming rules, and if it is under 150 percent FPL, then the person should be eligible for HCBS benefits right away, even though s/he cannot receive any other services until meeting the SOC.

We note that there are several ambiguities in Section 1915(i), and so there is not one perfectly correct interpretation. Since the DRA provision specifically mentions "income and resource rules," we understand why CMS chose to interpret it the way they did. However, it is possible that the mention of resources in 1915(i)(3) was just a general description of the fact that 1902(a)(10)(C)(i)(III) *relates* to income and resource rules applicable in the community, and did not mean that the resource rules themselves were directly applicable to the determination of eligibility for HCBS benefits.

We posed the above scenarios informally to CMS and were given additional informal guidance that in certain respects seems broader than the Proposed Rule. For example, we were told that the 150 percent FPL test is never an issue for the medically needy because once incurred medical expenses are considered, the medically needy population is virtually always below 150 percent FPL. Yet at the same time, this guidance stated that States have the option to waive community income and resource rules for medically needy individuals receiving 1915(i) services. Again, this seems to suggest that the medically needy test is applied twice–once for regular benefits and once for HCBS benefits. But if a person has already passed the regular medically needy test, then s/he will, by definition, pass the "optional" test because that income will always be the same or lower, as will resources. So under that interpretation, the option in 1915(i)(3) is completely illusory.

We believe the 1915(i)(3) should apply to the 150 percent FPL test, and the test should be applied after a person has been found eligible for the MN program, even if the person has not met the SOC yet. We understand this interpretation is not perfect either, since a person is not truly eligible under the State Plan until they actually meet the share of cost, but it gives some meaning to 1915(i)(3).

Additionally, the informal CMS guidance stated that spousal impoverishment eligibility rules may be applied. We do not understand how this is true, and would respectfully request an example.

Lastly, could CMS provide clarification and guidance about how Medicaid Buy-In Programs (such as those offered through the Balanced Budget Act of 1997 and Ticket to Work Program and Work Incentives Improvement Act of 1999), and the Breast and Cervical Cancer Prevention and Treatment programs interface with the new 1915(i) HCBS State Plan option? Individuals in these programs often earn more than 150 percent FPL. Is CMS considering special provisions under 1915(i) that apply to these important populations and circumstances?

MANAGED CARE

It would be helpful if CMS could provide guidance as it relates to managed care. Specifically, would individuals in managed care plans continue in their plans but receive 1915(i) HCBS services through a fee for service environment, or would they be required to receive these services through their managed care plans?

INDEPENDENT ASSESSMENT AND PLAN OF CARE

The Proposed Rule requires an independent entity to 1) perform an evaluation (determine a person's eligibility for 1915(i) services related to needs-based threshold for HCBS), 2) conduct an individual face-to-face assessment to determine the specific services needed by the individual, and 3) establish a written individualized plan of care for the person. We note that the Proposed Rule, on page 18680, under "6. Independent Assessment" states, "...we would propose specific requirements for independence of the assessor in accord with section 1915(9)(1)(H)(ii) of the Act, and we would apply these also to the evaluator and the person involved with developing the plan of care, where the effects of conflict of interest would be equally deleterious."

We are concerned that the above 1915(i) requirements, together with the new Targeted Case Management interim final regulation (effective March 3, 2008), will result in an eligible person receiving 1915(i) case management services going through two assessment and care planning processes. First, an independent entity would perform a comprehensive assessment and establish a care plan for a person under 1915(i). Second, the person would be required to have another comprehensive needs assessment and plan of care conducted by his or her case manager to fulfill two of the four elements required under the Targeted Case Management regulation. Thus, the combination of the Home and Community-Based State Plan Services regulation and the Targeted Case Management regulation creates duplication of services and

costs, and undermines State administrative efficiencies in providing HCBS as a State Plan benefit. Furthermore, in keeping with recognized standards of practice and service delivery, individual providers of other covered HCBS perform their own assessments and care plans for patients before providing services to them.

If case managers have access to the initial independent needs assessments in a manner that complies with HIPAA privacy and authorization constraints, they may be able to develop plans of care without having to perform their own assessments anew. We would like clarification that this scenario (using bona fide needs assessments conducted by independent parties) would still qualify all the other services they perform as case management under the new Targeted Case Management regulation, and that these case managers would still be able to bill these services in accordance with the regulatory provisions.

INITIAL INFRASTRUCTURE FOR THE 1915(i) OPTION AND FUTURE AMENDMENTS

California would appreciate confirmation about our understanding of the general infrastructure and future amendments to the 1915(i) State Plan option. California's understanding, based on the written regulation and follow up conversations with CMS, is that the State could establish and implement an infrastructure of the independent assessment piece through a State Plan Amendment (SPA), and if the State is ready to actually include services at the time the infrastructure is set up, it could include those services in the initial SPA as well. The infrastructure of the 1915(i) option could include:

- Assessment criteria
- Who will do the assessment
- Where the assessment would be done
- Who will do the care planning and how the care planning process will take place
- Who, how, and frequency of the assessment follow-up process, and
- State oversight process

If the State includes actual services, the SPA would need to include:

- Specific services and their descriptions
- Critical path from initial contact through the eligibility/assessment/care planning process to actual receipt of services, especially how a person gets linked to the independent eligibility/assessment/care planning process when contact is initially made directly to a HCBS provider of the service (such as a walk-in to a center)

- Relationship of the independent assessment process for 1915(i) services and the HCBS provider assessment done at the point of service, and
- State oversight process

Furthermore, our understanding is that in the future, the State can move additional services and programs under the 1915(i) provision via additional State Plan Amendments. We appreciated CMS' feedback on this during a recent call, because setting up the infrastructure and determining services to include can be an overwhelming task. Allowing States the ability to initialize a program, gain experience with it, and plan for expansion makes sense. We realize that a State may also find that the assessment criteria is not optimal, and may want to refine it with future amendments.

The State of California appreciates the opportunity to review and comment on this important Proposed Rule. If you require further information regarding these comments, please contact me at (916) 440-7400.

Sincerely,

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