JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

November 13, 2023

Center for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier/OMB Control Number: CMS-2023-0154; CMS-R-21; CMS-8003,
Room C4–26–05,
7500 Security Boulevard
Baltimore, Maryland 21244–1850
Submitted Electronically via www.regulations.gov

Re: **Comments on 1915(c) HCBS Waiver Application and Instructions, Policy and Technical Guide**

Dear Mr. Curtis Cunningham and Colleagues:

We write to comment on the proposed 1915(c) Application and 1915(c) Instructions, Technical Guide, and Review Criteria. Justice in Aging is a national non-profit organization committed to protecting the rights of older adults and individuals with disabilities, including persons who rely on home and community-based services. We focus our efforts particularly on those who have been marginalized and excluded from justice such as older adults of color, older women, LGBTQ+ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency.

Based on statements made by CMS representatives at the HCBS Advocacy Coalition stakeholder meeting on October 23rd, we understand CMS seeks limited feedback at this time, as it intends to reissue these documents for more substantive comments following the finalization of the Medicaid Access Rule. Accordingly, we have limited our comments to a significant extent, with most of the substantive comments relating to changes proposed by CMS, including changes implementing the HCBS settings requirements. We also make several technical and editorial suggestions.

Comments on "Instructions, Technical Guidance, and Review Criteria"

I. Appendix B: Participant Access and Eligibility

A. Brief Overview

The Instructions state that federal financial participation (FFP) is not available until the date of service plan completion, but this fails to recognize the availability of FFP under a provisional plan of care. Accordingly, we recommend the following revisions:

…No FFP is available for waiver services prior to the date that the service plan is completed, except for waiver services provided under a provisional written plan of care, pursuant to CMS State Medicaid Director letter Olmstead Update #3 (July 25, 2000), and as referenced in Item D-1-d-I, Service Plan Development Process. Also, FFP for activities related to the entrance of a person to the waiver…

B. Appendix B-5 Post-Eligibility Treatment of Income

The section states that states "must" apply spousal impoverishment protections to all married persons seeking HCBS waiver coverage. This fails to acknowledge the rule of construction of the Medicaid Act dictating that a Medicaid program may choose to evaluate an HCBS applicant's eligibility without considering the spouse's finances.[1] We recommend the following language:

a. Overview
   As of January 1, 2014, and extending through September 30, 2027 (or other date as required by law), states generally must apply the eligibility and post-eligibility methodologies described in section 1924 of the Act (the spousal impoverishment statute) to all married individuals seeking eligibility under the category described at 42 CFR § 435.217…

   …A state has the option to consider financial eligibility without regard to a spouse's finances, as explained in State Medicaid Director letter #21-004. This flexibility extends to new waivers and to renewals, and a state adopting this flexibility should modify waiver terms accordingly, in Appendix B-5 specifically.

b. Post-Eligibility Treatment of Income: Overview
   … For the period beginning January 1, 2014, and extending through September 30, 2027 (or other date as required by law), states must use spousal impoverishment rules, unless the state has exercised its discretion to consider an applicant's eligibility without regard to a spouse's finances, through the flexibility explained in State Medicaid Director letter #21-004.

c. Allowance for a Spouse
   … For the period beginning January 1, 2014, and extending through September 30, 2027 (or other date as required by law), states must use spousal impoverishment rules, unless the state has exercised its discretion to consider an applicant's eligibility without regard to a spouse's finances, through the flexibility explained in State Medicaid Director letter #21-004 (Dec. 7, 2021).

- B-5-a, B-5-d, B-5-g
  In reference to spousal impoverishment protections, the Instructions in the following locations unnecessarily note that those protections do not apply prior

[1] *See* Section 3(b), Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39, as explained in State Medicaid Director #21-004.

to January 1, 2014. We recommend deleting the many references to the time period before or after January 1, 2014 in the following sections of the guidance:

- General Guidance Concerning Completing Appendix B-5,
- Detailed Instructions for Completing Appendix B-5,
- Item B-5-b: Regular Post-Eligibility Treatment of Income: Section 1634 and SSI Criteria State
- Item B-5-c: Regular Post-Eligibility Treatment of Income: Section 209(b) State
- Item B-5-e: Regular Post-Eligibility Treatment of Income: Section 1634 and SSI Criteria State
- Item B-5-f: Regular Post-Eligibility Treatment of Income: Section 209(b) State
- Item B-5-g: Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

C. Detailed Instructions for Completing Appendix B-4

Instructions:

We recommend adding the word "a." The revised sentence should read, "Select whether the state is (a) a section 1634 state; …"

Technical Guidance:

For clarity we recommend the following amendment: "The state applies rules that are more restrictive than SSI, but no more restrictive than the standards used by that state's Medicaid program on January 1, 1972, in determining the Medicaid eligibility of SSI beneficiaries." [We also have deleted the hyphen that currently is between "SSI" and "beneficiaries."]

D. Item B-7: Freedom of Choice

Under 42 CFR § 441.302(d)'s freedom of choice provision, waiver recipients must be able to choose between institutional and waiver services. While historically, this has been interpreted to mean that participants must affirmatively turn down institutional services, we urge CMS to require that states inform applicants of all HCBS programs that are available to them. We suggest the following amended language:

Technical guidance**:**

"…The procedures should include ensuring that the individual (or the individual's legal representative) exercises an informed choice, including being informed of all HCBS services the individual may access as an alternative to institutional care."

CMS Review Criteria**:**

"The procedures described ensure that individuals are provided information about all waiver services available to them as an alternative to institutional care."

II. Appendix C-5: Home and Community-Based Settings Requirements

A. *Comparability*

The HCBS settings requirements give a state several ways to comply with the eviction rights provision. We recommend that those be broken out in the Application, so there is clarity between the state and CMS as to the state's strategy. We recommend offering states the following four options, listed under the initial assurance that the unit is a specific place and the participant has landlord-tenant rights or something comparable:

1. The unit or dwelling 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 tenants have under the landlord/tenant law of the state, county, city, or other designated entity.
    1. Landlord/tenant laws apply to the individual and their setting.
    2. The individual's eviction rights are established by a written agreement between the provider and the individual receiving services. The state develops language that sets forth the relevant eviction protection rights, and requires that agreements include that language.
    3. The individual's eviction rights are established by a written agreement between the provider and the individual receiving services. The provider must ensure that each agreement includes language that sets forth the relevant eviction protection rights.
    4. Other. [Explain]

B. Appendix D: Participant-Centered Planning and Service Development

1. D-1-a: Responsibility for Service Plan Development

Inadequate knowledge among care managers can obstruct the delivery of person-centered care. To ensure these individuals are competent on the HCBS settings requirements, we suggest the following alternative language:

Technical Guidance: Given the importance of the role of the person-centered service plan in HCBS provision, states must train those responsible for service plan development in HCBS settings requirements and person-centered plan development.

CMS Review Criteria: The state affirms its commitment to providing training for the individuals responsible for service plan development, focusing on HCBS settings requirements and person-centered plan development.

2. D-1-b: Service Plan Development Safeguards and D-2-b: Monitoring Safeguards

To effectively implement the conflict-of-interest protections specified in sections D-1-b and D-2-b, stronger oversight measures are imperative, especially in cases where recipients are serviced by entities providing both case management and services. We recommend adding the following language:

Technical Guidance: Direct oversight of the process or periodic evaluation by the state agency must include participant feedback. States must provide an oversight plan that monitors a participant's right to free choice of provider, awareness of

waiver services, participation in service plan development and updates, and overall ISP and service satisfaction.

CMS Review Criteria: Waiver includes an oversight plan, which includes participant feedback, to ensure compliance with person-centered service plan development.

3. *D-1-d-i: Service Plan Development Process*

To ensure states prioritize person-centered care in compliance with HCBS settings requirements, CMS must issue comprehensive instructions, technical guidance, and review criteria. We recommend CMS add the following language:

Technical Guidance:

…(b) the types of assessments that are conducted to support service plan development, including securing information about participant needs, preferences and goals (both medical and nonmedical), and health status, including who conducts the assessments; (c) how the participant is informed in an accessible and culturally competent manner of the services that are available under the waiver and non-waiver services; (d) how the plan development process ensures that the service plan addresses participant goals (including community-integration goals), needs (including health care needs), and preferences… and, (h) how the participant directs and/or engages in ~~and/or directs~~ the planning process.

CMS Review Criteria:

- The types of assessments that are conducted as part of the service plan development process, including securing information about participant strengths, capacities, needs, preferences, community-integration goals, and desired outcomes, health status, and risk factors;
- How the participant is informed of services available under the waiver and nonwaiver services that address their goals;
- How the process ensures that the service plan is tailored to the individual to address~~es~~ participant desired outcomes, community-integration goals, needs and preferences;
- How the process addresses participants' health care needs and social determinants of health;
- As the individual receiving care is the foremost expert on their care needs, the state must specify how the participant directs and/or ~~directs~~ engages in the planning process.

4. *D-1-f: Informed Choice of Provider*

Given the complex needs of the recipient population, more robust technical guidance and evaluative criteria are needed to ensure informed decision-making. We recommend the following amendments:

Technical Guidance: To effectively exercise this right, participants must be provided information in an accessible manner, adhering to federal and state language access requirements, presented in plain language to increase understanding, and promote culturally competent care that aligns with recipient needs…Such information may be furnished as part of the service plan development process or by other means of personalized support…

CMS Review Criteria:

- Participants are provided on an ongoing basis with accessible information (~~in a manner consistent with their needs.~~ this information must adhere to federal and state language access requirements, be presented in plain language, and promote culturally competent care that aligns with recipient needs) about choice of qualified providers and available service providers.
- States specify the personalized support available to participants to ~~are~~ support~~ed~~ ~~in selecting~~ their informed selection of providers.

5. *D-1-G: Process for Making Service Plan Subject to the Approval of the Medicaid Agency*

To ensure the uniqueness and person-centered nature of each ISP, and to promote health and welfare of waiver participants, we recommend that the following language be added:

Technical Guidance:
This oversight activity is a critical element of the Medicaid agency's responsibility to actively oversee the operation of the waiver and ensure health and welfare of recipients.… It must, therefore, include a representative sample of ISPs to verify their uniqueness to the respective recipients and describe the process the state will use to validate the person-centered nature of these ISPs.

CMS Review Criteria:

- The process described to review plans indicates that the Medicaid agency exercises oversight of service plans on a routine and periodic basis. The waiver includes a review process to ensure a practice of person-centered service planning.
- If an in-depth review of a sample of service plans is conducted…The state certifies that the sample of service plans is representative of the demographic makeup of the waiver population.

6. *Item D-2- Quality Improvement: Service Plan*

To ensure that waiver programs effectively serve the needs of recipients, states must collect and analyze feedback from program participants. We recommend the following amendments, which prioritize recipient feedback:

Instructions:

…These monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems and individual corrective actions. At a minimum, discovery processes must solicit feedback from participants on the delivery of their waiver services…

Technical Assistance:

…Specifically, the evidence produced as a result of discovery and remediation activities should provide a clear picture of the state's compliance in meeting an assurance. At a minimum, states must collect feedback from a representative sample of waiver participants to inform oversight and improvement efforts.

CMS Review Criteria

- Service plans address all participants' assessed needs (including health and safety risk factors) and personal and community-integration goals, either by waiver services or through other means.

C. Attachment: Core Service Definitions

Other Services: 10. Adult Foster Care: The description of Assisted Living Services includes a mention that the setting must be compliant with the setting requirements, but the description of Adult Foster Care does not include that language. We propose the following revision:

> … Adult foster care is furnished to adults who receive these services in conjunction with residing in the home, which must meet the HCBS setting requirements…

Comments on the "Application for 1915(c) Home and Community-Based Services Waiver"

A. Appendix B-5: Post-Eligibility Treatment of Income

The Application states that spousal impoverishment rules are mandatory through September 30, 2027, but this does not recognize the flexibility granted states to consider financial eligibility without regard to the spouse's finances. This flexibility is based on the rule of construction of the Medicaid Act under section 3(b) of the Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39, as explained in State Medicaid Director letter #21-004. We recommend states be given a check-box option to use the following language:

Under the authority of section 3(b) of the Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39, as explained in State Medicaid Director letter #21-004, the state evaluates financial eligibility based on the applicant being a household of one, without regard to the community spouse's finances.

In a related matter, we note that references to the spousal impoverishment protections consistently give states the option of not using spousal impoverishment protections for any time prior to January 1, 2014. This is obviously a dated reference; we recommend deletion of all such references to January 1, 2014.

B. Appendix C-5

In subsection 2, the state is required to describe how it will ensure that settings are compliant with the settings requirements. We recommend that this item be revised to make it clear that a state must include a grievance mechanism to accept and resolve grievances submitted by participants, their representatives, and other interested parties. We recommend the following language:

...(Describe the process that the state will use to assess each setting, including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received, and how the state will accept and resolve grievances submitted by individuals receiving services, their representatives, and other individuals.)

Issues for Future Consideration

Through our advocacy for state HCBS programs, we believe that states need additional guidance from CMS in creating 1915(c) applications. Before reissuing the 1915(c) Application for public comment after the finalization of the Medicaid Access Rule, we urge CMS to include additional requirements such as performance measures that are bolstered by mandatory data collection to support equity and quality monitoring activities; participant rights and mandatory grievance procedures; and strengthened enforcement mechanisms that reflect the full incorporation of all HCBS settings requirements. We also encourage CMS to engage in meaningful conversations with the HCBS Advocacy Coalition and other stakeholders on opportunities to improve the waiver Application.

In the meantime, we would be happy to meet with your team to discuss our areas of concern. You can contact us at ecarlson@justiceinaging.org.

Sincerely,

Eric M. Carlson
Director, Long-Term Services and Supports Advocacy