



April 26, 2011

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2337-P  
Post Office Box 8016  
Baltimore, MD 21244-8016

**Re: CMS-2337-P, Medicaid Program; Community First Choice Option**

To Whom It May Concern:

The Home Care Association of New York State (HCA) is a statewide not-for-profit organization representing nearly 400 home health care providers, allied organizations and individuals involved with the provision of home care in New York State to approximately 400,000 patients. HCA's mission is to promote and enhance the quality, accessibility and availability of home care by enabling its members to meet the health and assistive needs of frail elderly, chronically ill and disabled New Yorkers.

HCA appreciates the opportunity to provide comments on the proposed rule to implement the Community First Choice Option program.

New York State has a very comprehensive Medicaid home and community-based infrastructure that includes Certified Home Health Agencies, Long Term Home Health Care Programs, Licensed Home Care Services Agencies, Managed Long Term Care, several home and community-based services waiver programs under section 1915(c) of the Social Security Act, and the Consumer Directed Personal Assistance Program.

Our members participate in one or more of these programs, and our comments are based on their experiences with each of these programs and how we believe the Community First Choice Option will affect the current home care delivery system in New York, including providers and patients.

In general, we are concerned that the proposed regulations do not recognize that there may be other services and programs that can meet the needs of those applying for the Community First Choice Option. We advocate that states should be required as part of their assessment process under the Community First Choice Option to determine if Community First Choice or some other state program is appropriate to meet their needs. Also, there is no recognition that certain entities that are vital components of Community First Choice, such as the financial management entity, may already

exist and be serving a similar role in another state program and what role they should play in this new program.

#### **Assessment of Need** (section 441.535)

Though states must conduct a face-to-face assessment of an individual's needs, strengths and preferences under the Community First Choice Option, there is no mention of any responsibility of the entity conducting the assessment to determine if the individual is appropriate for this program or if there are other programs that may meet his or her needs. We advocate that language be added to require a comprehensive assessment of an individual's needs and appropriateness for other state plan services and/or home and community-based waiver programs so that the consumer can be offered a choice of programs and not be limited to one model of care. Such an assessment tool is recognized as a vital component of other federal programs, including the new *State Balancing Incentive Program*, and is used or being developed by some states, including New York.

In addition, there is no requirement on the qualifications of the person conducting the assessment of need. We recommend that a nurse or other trained professional should be responsible for the assessment.

#### **Service Plan** (section 441.540)

CMS proposes that states must ensure that certain conflict of interest standards for assessment of need and service plan development apply to all individuals and entities, public or private. One of these standards is that the entities conducting the assessment of need and developing the service plan would not benefit financially from the provision of assessed needs and services [section 441.540(c)(4)(iv)].

This provision needs further clarification, but if it means that a provider who conducts an assessment cannot also provide one or more services to individuals under the Community First Choice Option, this would create major conflicts with our delivery system in New York. For many years, New York State has pioneered and fundamentally predicated its core models of long term care and home care on consolidation of the assessment, care management and service delivery functions within and at the provider level. All of these functions are subject to strict regulations and oversight. This policy and clinical approach has resulted in the successful, cost-effective and timely integration and provision of services in accordance with the individual's needs. Such a prohibition on this coordinated approach to care should not be part of Community First Choice and we believe is not required by the statute.

#### **Service Models** (section 441.545)

The statute defines agency-provider model as a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports, and services are selected, managed and dismissed by the individual. The regulations further state that under the agency model, individuals maintain the ability to hire and fire the providers of their choice for the services identified in their person-centered service plan.

However, HCA questions how this will work in practice. The rule must ensure that the scope and authority it provides for the consumer's "hiring and firing" of the worker are complementary,

appropriate and in sync with the agency's business and employment model, all applicable agency regulations and basic employee protections.

The regulations need to include a clear delineation of the roles and responsibilities of the consumer and the agency under this model. For example, if the consumer "hires" the worker, what is the protocol if the agency discovers that the worker did not reveal a criminal history, did not obtain the required health tests, delivered poor care or is falsifying time sheets? Under this model, would it be the agency's right to fire or reassign a worker if the consumer disagreed? If the consumer "fires" the worker and the worker cannot be given another patient, what are the implications, including basic protections, for the worker?

Under the self-directed model with service budget, an integral role is played by a financial management entity who handles payroll, budget and other issues. New York's Consumer Directed Personal Assistance Program also utilizes financial management entities called fiscal intermediaries to handle similar tasks for consumers who select their own workers. The proposed regulations should recognize such entities and include language that those entities that have been approved to serve a similar role under a state program should be automatically approved or allowed to face a streamlined approval process to provide similar services under the Community First Choice Option program.

#### **Provider Qualifications** (section 441.565)

CMS proposes that states must provide assurances that necessary safeguards have been taken to protect the health and welfare of enrollees in the Community First Choice Option and must define the qualifications for providers in the agency model. However, there is no requirement for states to define the qualifications of providers who are not part of an agency, such as family members, friends or others. This is a serious omission that must be corrected.

There should be minimum safeguards that states must meet in establishing provider qualifications whether from an agency model or a self-directed model. These standards should include caregiver training and competencies, health assessments, quality assurance systems and others. In addition, there need to be certain safeguards and oversight to ensure that services have been provided appropriately and at the level that is authorized.

I hope these comments are helpful and I am available to answer any questions. I can be reached at (518) 810-0662.

Sincerely,



Andrew Koski  
Vice President for Advocacy and Public Policy