



June 3, 2008

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2249-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: File Code CMS-2249-P

Dear Sir/Madam:

The Home Care Association of New York State (HCA) appreciates the opportunity to submit comments on CMS' proposed rule (CMS-2249-P) that would implement section 6086 (Expanded Access to Home and Community-Based Services for the Elderly and Disabled) of the Deficit Reduction Act (DRA) of 2005.

HCA is a statewide not-for-profit organization representing over 400 health care providers, allied organizations and individuals concerned with the provision of home care in New York State. HCA and its home health provider members work to promote excellence and support high-quality, cost-effective home care and community services to individuals who have Medicaid, Medicare, and/or private insurance coverage.

New York State has a comprehensive Medicaid home and community-based infrastructure that includes a wide array of State Plan home care services, managed long term care, and waiver programs under section 1915(c) of the Social Security Act. These waiver programs include the Long Term Home Health Care Program, which was a major prototype in the development and the enactment of the national home and community-based waiver services law, as well as a Traumatic Brain Injury program, Katie Beckett/Care At Home program, and the more recent Nursing Home Transition and Diversion Waiver and Money Follows the Person initiatives. Our members participate in these programs, and our comments are based on their experiences.

We appreciate the intent of the new rule in providing flexibility to states for the provision of home and community-based services. The dynamic nature of home care requires the greatest flexibility possible for the optimal effectiveness and efficiency of these services and care models. We observe that the increasing web of federal policy rules and restraints are constraining our providers and our system generally. Our 1915-c waivers and the programs they enhance are vital to our infrastructure and our ability to provide home-based options for individuals who would otherwise necessitate institutional placement. We urge that these rules and/or any other new federal authority allow us to increase the scope and flexibility of our current waiver programs and state plan structure – and we caution that the proposal not include provisions that would inadvertently limit or compromise the infrastructure we have developed. We are concerned that among the provisions of proposed rule 2249-P are components which would in fact run contrary to our infrastructure, including long-standing models of care with proven records of success.

While HCA has numerous comments on the proposed rule, we have focused our comments on the following selected provisions.

§441.559(d) Independent Evaluation; 441.562 Independent Assessment; and 441.568 Provider Qualifications

In the rule, CMS proposes that providers of State plan Home and Community-Based Services (HCBS) or those who are employed by a provider of State plan HCBS can **not** conduct evaluations of eligibility for such services or assessments of need, or develop plans of care. The sole exception would be when the only organization available to perform such tasks in a geographic area also provides HCBS and the state devises conflict of interest protections.

The rule would limit states to the development or use of models that contradict decades of long term care policy and efforts to coordinate an otherwise fragmented system.

In response to system gaps and problems that were identified as far back as the 1970's, New York State deliberately moved toward models that consolidate evaluation, assessment, care planning, case management and the provision of services into integrated, single entry systems. These programs enable patients to more seamlessly access services and receive coordinated, integrated plans of care. Long Term Home Health Care Programs, Managed Long Term Home Health Care Programs, PACE programs and our traditional certified home health agencies are examples of such models. The proposed rule appears incompatible for use in supporting such integrated care models, and instead limits states to models that lead back to fragmentation.

CMS' proposal to remove providers from participating in assessments and evaluations does not appear required by the DRA which only mandates that the State establish standards for the conduct of the evaluation and the assessment to safeguard against conflicts of interest.

In New York State, home care providers have a long history of conducting assessments and developing and providing plans of care. They have handled these "dual" functions in ways that promote quality care and the State has devised other ways to ensure that care is delivered appropriately.

HCA requests that CMS remove from the proposed rule the prohibition on providers' ability to carryout these critical functions and deliver the needed services to their patients.

§440.182 State Plan Home and Community-Based Services Benefit

This section references the services which may be provided as State plan home and community-based services under the proposed rule.

The services which would be authorized under the proposed rule appear to be a defined list which is narrower than currently allowed under the flexible §1915-c home and community-based waivers. It is not clear how or whether services in addition to the prescribed list would be covered under the proposed rule, whether for new or existing programs – and, particularly, for programs that currently provide expanded services through §1915-c waivers. HCA requests clarification of the implications of and opportunities under the proposed rule for programs currently providing services pursuant to such waivers. HCA requests that opportunities to supporting such waiver programs be permissible and supported under the proposed rule.

With respect to the specific exclusion of housing assistance – room and board – under the proposed rule, HCA emphasizes that as such assistance is an integral component of care in a health related facility, it is

comparable to include the authority for states to provide such assistance in programs which offer alternatives to institutional care. In order to make such alternatives viable for individuals who without housing assistance must seek institutional placement, the proposed rule as well as options under home and community-based services waivers should include the authority and federal financial participation to provide such assistance.

§441.556 Eligibility for Home and Community-Based Services Under Section 1915(i)(1) of the Act

One of the eligibility requirements for State plan HCBS is that individuals possess income that does not exceed 150% of the federal poverty level (FPL). In determining whether this requirement is met, the proposed rule states:

“. . . the rules for determining income eligibility for the individual’s eligibility group under the State’s Medicaid plan, including any more liberal income disregards used by the State for that group under section 1902(r)(2) of the Act, apply.”

HCA seeks clarification that under New York’s medically needy eligibility category, individuals who “spend down” their income to 150% of the FPL would be eligible for State plan HCBS if New York chose to offer this new option.

§441.577 State Plan HCBS administration: State responsibilities and quality improvement

Presumptive Eligibility

Section 1915(i)(1)(J) of the DRA gives States the option of providing for a period of presumptive eligibility, not to exceed 60 days, for individuals the State has reason to believe may be eligible for the State plan HCBS benefit. HCA believes that CMS has incorrectly interpreted this provision to mean that federal Medicaid payments are available for evaluation of eligibility and assessment of need, but **not for the actual services** (§441.577(2)(i)(A)).

The concept behind “presumptive eligibility” is that some individuals have immediate needs and access should not be delayed due to the time required for a complete eligibility determination to be made and services to be initiated. Presumptive eligibility allows states to start services on a timely basis for those that appear to be eligible and receive federal financial participation (FFP). HCA believes that FFP should be available for HCBS **services** initiated under presumptive eligibility.

HCA appreciates this opportunity to provide written comments on CMS-2249-P. We respectfully request the incorporation of our concerns and recommendations in the final rule.

Please do not hesitate to contact me at (518) 810-0664 with any questions or requests for further information.

Sincerely,



Joanne Cunningham
President