October 15, 2015

Victoria Wachino, Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244
Via e-mail: Victoria.Wachino1@cms.hhs.gov

**Re: Request for Revision of Medicaid Policy to Eliminate Coverage Gap in Home and Community-Based Services, In Accord with Recent Federal Court Ruling**

Dear Ms. Wachino:

The undersigned are national groups representing the interests of older persons and persons with disabilities. We write to request that the Centers for Medicare and Medicaid Services (CMS) immediately take steps to revise Medicaid coverage rules that unfairly limit consumer access to home and community-based services (HCBS). The need for action is demonstrated by a recent federal court ruling that CMS's current policies conflict with the Medicaid Act, as discussed below.

The Federal Statute and CMS's Current Policy

Under the Medicaid Act, Medicaid programs must provide coverage for up to three months prior to the month of application, for any time during which the applicant met eligibility requirements.[1] This requirement protects applicants from being saddled with unaffordable health care bills during the transition from private-pay status to Medicaid eligibility. Because of this protection, an applicant should not be disadvantaged by the time required for a Medicaid program to process an application, since coverage can extend back not only to the date of application, but also to three months prior to the application month.

Unfortunately, current CMS policy denies this protection when an applicant requests coverage of home and community-based services. For HCBS provided pursuant to an HCBS waiver, coverage is prospective-only from the date on which the state Medicaid program (or its agent) approves an HCBS service plan, as explained in CMS's technical guidance:

[1] 42 U.S.C. § 1396a(a)(34); *see also* 42 C.F.R. § 435.915(a) (implementing regulation).

> Federal financial participation (FFP) may not be claimed for waiver services that are furnished prior to the development of the service plan or for waiver services that are not included in an individual's service plan. A service plan may not be backdated.
> …
> FFP may be claimed only for those waiver services that are included in the service plan and may not be claimed for services furnished prior to the development of the service or for services not included in the service plan.[2]

CMS's Policy Significantly Limits Access to Home and Community-Based Services

Because of CMS's policy, many consumers are unable to access Medicaid HCBS coverage for which they are otherwise eligible. If a person already receives home and community-based services at the time of filing an application, he or she likely will incur unaffordable charges in the time between when a Medicaid application is filed, and when the Medicaid program (or its agent) makes a formal level-of-care determination and/or approves the Medicaid service plan. Other persons may never receive home and community-based services, or have their needed home and community-based services delayed, because they and/or their HCBS providers cannot take the financial risk of HCBS being provided during the pendency of a Medicaid application, when Medicaid coverage will not be available. For some, Medicaid waiver coverage delays will increase the risk of unnecessary institutionalization.

The contrast with Medicaid's coverage of nursing facility expenses is striking and instructive. Assume that a person has a medical need for nursing facility services or the equivalent, and is considering whether to enter a nursing facility or an assisted living facility. Under those circumstances, CMS's coverage policies strongly incentivize choosing the nursing facility over the less-institutional assisted living services. A Medicaid program will cover nursing facility expenses up to three months prior to the month of application, but will cover assisted living services only prospectively from the date a service plan is approved.

A Federal Court Recently Ruled that CMS's Policy Violates the Medicaid Act

In *Price v. Medicaid Director*,[3] two assisted living residents filed a class action suit against the Ohio Medicaid program and its agents, alleging that the state violates section 1396a(a)(34) by granting assisted living coverage only prospectively from the date of service plan approval. On September 1, 2015, the court granted summary judgment in the residents' favor, certifying a statewide class of similarly situated individuals and ordering the state to bring its assisted living program into compliance with section 1396a(a)(34) — namely, to offer coverage up to three months prior to the month of application, for all days, weeks or months for which the applicant meets eligibility requirements.

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[2] CMS, Instructions, Technical Guide and Review Criteria, Application for a § 1915(c) Home and Community-Based Waiver, at 46, 178 (Jan. 2015); *see also* CMS, Olmstead Letter No. 3, Attachment 3-a (Earliest Eligibility Date in HCBS Waivers) (July 25, 2000) (coverage not available until approval of service plan).

[3] Case No. 1:13-cv-74, 2015 WL 5117895, 2015 U.S. Dist. LEXIS 116384 (S.D. Ohio 2015). A copy of this ruling is enclosed with this letter.

In defending against the lawsuit, the state relied heavily on CMS's HCBS coverage policy, but the court found that "CMS's interpretation is not warranted deference because it lacks any rationale and is contrary to the clear intent of Congress."[4] As the court explained, section 1396a(a)(34) was enacted for two primary reasons: to protect persons from being billed privately while meeting Medicaid eligibility standards, and to encourage providers to provide services prior to eligibility being formally granted. CMS's policy, however, "runs counter to these dual purposes," according to the court.[5]

CMS's HCBS coverage policy was also found to be inconsistent with the HCBS waiver statute, 42 U.S.C. § 1396n(c). HCBS waivers are meant to provide a non-institutional alternative to nursing facilities, but the CMS policy creates a financial incentive to enter a nursing facility rather than receive HCBS:

> By prohibiting retroactive coverage, Ohio's assisted living waiver program frustrates Congress's goal of furthering deinstitutionalization and lowering Medicaid expenditures for individuals who would otherwise require nursing home care but with supportive services can live safely in the community. Because of the delays inherent in Ohio's post-application processes, individuals are faced with remaining institutionalized in a nursing home or choosing more expensive nursing home care in the first instance while they wait for Ohio to determine their eligibility.[6]

Notably, the court found that HCBS can be "provided pursuant to a written plan of care" (as required by section 1396n(c)) even if services are provided before the plan of care (or "service plan") is approved. Once a service plan is approved, a Medicaid program can look back on the coverage period required by section 1396a(a)(34). If services provided that time were "in compliance with" or "in accordance with" the service plan, they can be covered. If not, those services will not be covered, subject to the applicant's appeal rights.[7]

Conclusion:
CMS Should Revise its HCBS Coverage Policy to Eliminate the Current Disincentive to Use HCBS

For the reasons described above, we believe that the current HCBS coverage policy is not supportable. It inappropriately creates an incentive to choose institutional care over HCBS, and cannot be reconciled with the clear requirements of section 1396a(a)(34). The *Price* decision is well-reasoned, and likely will be very persuasive in any future challenge to a state Medicaid program's refusal to cover HCBS prior to service plan approval. Although the Price plaintiffs' claims were based primarily on the Medicaid Act, claims may also arise under the Americans with Disabilities Act and the Olmstead mandate for similarly situated individuals for whom a delay in Medicaid waiver coverage leads to increased risk of unnecessary institutionalization.

We appreciate CMS's efforts in recent years to develop non-institutional alternatives for Medicaid consumers who need long-term services and supports. Revision of the HCBS coverage policy, as

[4] Price v. Medicaid Director, at 39.
[5] *Id.* at 41.
[6] *Id.* at 43.
[7] *Id.* at 31.

described in this letter, is an important and necessary next step. Accordingly, we request that CMS as soon as possible issue necessary guidance that announces the availability of HCBS coverage pursuant to section 1396a(a)(34), without regard to the date on which a service plan is approved. The policy revision should apply to all HCBS, whether provided in a private home, residential facility, or other setting.

Thank you for your consideration of this issue. Please contact Eric Carlson at ecarlson@justiceinaging.org or (213) 674-2813 with any questions or suggestions. We would be happy to meet with you and your staff to discuss any specifics of this issue and the policy changes that are required.

Thank you.

Sincerely,

AARP
ACCSES
Advance CLASS
Aging Life Care Association
American Association on Health and Disability
American Network of Community Options and Resources
Caring Across Generations
Center for Elder Care and Advanced Illness, Altarum Institute
Christopher & Dana Reeve Foundation
Community Catalyst
Family Voices
Justice in Aging
LeadingAge
National Academy of Elder Law Attorneys
National Council on Aging
National Council on Independent Living
National Health Law Program
United Cerebral Palsy

cc: Alissa Deboy, Director, Disabled and Elderly Health Programs Group
Kirsten Jensen, Director, Division of Benefits and Coverage
Ralph Lollar, Director, Division of Long Term Services and Supports
Kathy Greenlee, Administrator, Administration for Community Living