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July 2, 2012

## VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
PO Box 8016  
Baltimore, MD 21244-8016

**Attention: CMS-2249-P2  
Medicaid Program; State Plan Home and Community-Based  
Services, 5-Year Period for Waivers, Provider Payment  
Reassignment, and Setting Requirements for Community First  
Choice**

Dear Sir/Madam:

The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state levels. We appreciate the opportunity to provide CMS with comments on the proposed regulations for the § 1915(i) state plan HCBS benefit and the definition of integrated settings.

We provide comments below on the implementation of the state plan benefit emphasizing promotion of self-directed HCBS, person-centered services, and transparency and monitoring for HCBS programmatic standards. With respect to the integrated setting definition, NHeLP applauds CMS for the iterative process involving stakeholder input that has led to the proposed rule. We believe the rule represents an important advance in the integrated setting standard. Our recommendations emphasize the need for CMS to more zealously guard meaningful integration for persons with disabilities while at the same time recognize the viability of some HCBS settings which may be important for older adults. While it is difficult to generalize about these broad populations, and drawing clear definitions is a challenge, we recommend an approach which we believe reflects the objectives of many individuals who depend upon HCBS.

### **§ 430.25 Waivers of State plan requirements.**

The ACA creates authority for states to request 5-year initial approval periods for 1915(b) and (c) waivers that include dual eligibles, and allows renewals for 5-year periods. However, the ACA also qualifies that authority, allowing renewal “unless the

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Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.” Social Security Act § 1915(h)(2)(A). NHeLP recommends that the regulation be strengthened to clearly articulate the requirements for special 5-year approvals and extensions of waivers experimenting with system design for dual eligibles. For example, a waiver which effectively reduces services for dual eligibles should not be approvable as it is not “consistent with the purposes” of Title XIX. We recommend that CMS include in the regulation itself a requirement, like the one stated in the preamble to the regulation, that determinations “be made regarding applications for 5-year waivers in a manner consistent with the interests of beneficiaries and the objectives of the Medicaid program.” 77 Fed. Reg. 26831.

We believe that CMS should clarify whether a waiver is approvable for 5-year periods if it targets a population that includes only a very small proportion of dual eligibles.

#### **§ 435.219 Individuals receiving State plan home and community-based services.**

We commend CMS for proposing regulations to implement optional categorical eligibility for Medicaid for individuals in need of § 1915(i) services. This category has the potential to help secure coverage for uninsured and underinsured individuals, and will provide states with a useful option to consolidate coverage groups.

We commend CMS for the provisions at § 435.219(c) requiring no asset test for individuals in the 150% and below eligibility option, and requiring that states use income standards which are “reasonable, consistent with the objectives of the Medicaid program ... and in the best interests of the beneficiary.” We urge CMS to retain this policy and language.

We recommend that § 435.219(c) include a requirement that any alternate income methodology cannot be more restrictive than the SSI standard, as described at preamble at 77 Fed. Reg. 26385.

#### **§ 436.219 Guam, PR, and Virgin Islands**

See comments to § 435.219 above.

#### **§ 440.182—State plan home and community-based services**

We commend CMS for including at § 440.182(c) of the regulation the full set of services available under § 1915(c)(4)(B) and “other services requested by the agency and approved by the Secretary as consistent with the purpose of the benefit.” This standard creates equivalence between the § 1915(c) and § 1915(i) service options and provides

states will a meaningful option to equally provide HCBS services through their state plan instead of through a waiver authority.

We also commend the allowance of FFP for room and board and pre-discharge services in certain specific situations where such funding is in keeping with the purpose of promoting HCBS services.

### **§ 441.530 Home and Community-Based Setting**

NHeLP recognizes the difficulty in developing a working definition of “integrated settings,” and commends CMS’ open process for defining the term in this regulation. We are aware of many instances where CMS included stakeholder input in developing the regulatory definition. For example, stakeholders widely recommended removal of the term “custodial care” in describing institutional care and CMS heeded this suggestion. We believe CMS’ iterative development of the term “integrated setting” with stakeholders has led to a better regulation with wider acceptance. NHeLP makes additional recommendations below to improve the regulation further.

Broadly speaking, NHeLP believes CMS cannot pursue a strict one-size-fits-all framework for defining integrated settings. We believe that there are significant differences – regarding health and support needs, demographic factors, and preferences – between the disability and aging communities. Even if some of these differences may not be inherent, they reflect the actual historical trajectories of how the supports for these communities have developed. We therefore recommend that CMS develop and strictly enforce a broad framework for integrated settings and implement a specific and limited exception for certain aging community purposes. Our recommendation can be summarized as:

1. CMS should implement a strict integrated setting definition and requirement for HCBS services.
2. There should be no exception (or, at most, an extremely limited “rebuttable presumption”) for persons with disabilities receiving HCBS services in other settings.
3. With respect to certain settings for older adults, a less strict exception allowing HCBS services in other settings should be allowed if special criteria are met.

If CMS does not adopt our recommended approach, then CMS must improve the broad framework it has proposed. CMS will need to tighten the exceptions process with respect to persons with disabilities, who should never (or only in the rarest of circumstances) receive HCBS services in a diagnosis specific setting or on an institutional campus. At the same time, CMS may need to ensure the rule does not block older adults from settings which the aging community considers to be of value.

### *CMS' broad framework of integrated characteristics and rebuttable presumption*

NHeLP supports CMS' general approach of identifying the characteristics of integrated care and basing the regulatory definition on those characteristics. While we believe this approach does have the potential to capture the spirit of integrated care, we believe that CMS will need to take an active monitoring role to enforce the standards. More specifically, CMS will need to ensure that all of the individual pieces of the characteristic requirements are enforceable; if the characteristics become merely “factors” in a “totality of the circumstances” type of review, then the characteristics requirement will be eviscerated.

While we support the intent of the “rebuttable presumption” framework, we believe it is problematic. It is simply too weak a standard for the purposes of persons with disabilities. We believe the flexibility in the standard was largely designed to preserve access to some aging-related settings, which is why we have recommended a separate exception for the aging community. (CMS could also address this through a two-level rebuttable presumption; one very strong presumption in the disability context, and a lower one in the aging context). If the aging population has a separate exceptions process, the rebuttable presumption could be eliminated. In any case, if the rebuttable presumption remains, and is applied to persons with disabilities, the burden of proof for rebutting the presumption must be extremely high and met only in extraordinary circumstances. Furthermore, for any rebuttable presumption, CMS would need to establish clear standards and actively monitor around rebuttable presumptions to ensure that the exception does not swallow the rule. We note that large institutional settings in states may sometimes have important economic and political power at the local level which could surely influence the enforcement of this standard if CMS does not take an active role.

Since a setting must presumably be in compliance with the regulatory characteristics in § 441.656(a)(1) to be considered integrated, it is unclear what additional evidence it would need to produce to meet the rebuttable presumption. CMS will need to provide further guidance on this. We recommend that, if CMS allows a rebuttable presumption, CMS require at least the following two conditions be met:

1. The setting should have a higher burden of proof – such as “clear and convincing” evidence of compliance – with respect to satisfaction of all of the integration characteristics listed in the regulation.
2. We consider that the problematic physical attributes of some settings particularly threaten the community integration characteristic expressed in the regulation at § 441.656(a)(1)(i). Therefore, we recommend that any setting with one of the physical attributes described in § 441.656(a)(2)(v), which is over a certain size (definition to be determined by CMS), which is of a certain type (definition to be determined by CMS), or which is diagnosis/disability specific, must develop a

publicly available community integration plan and document compliance with it, including compilation of complaints filed by individuals related to community integration or to the plan.

We urge CMS to be especially strict in allowing exceptions to settings with the physical attributes described in § 441.656(a)(2)(v) and diagnosis/disability specific settings. We believe these settings bear the hallmarks of institutionalization and consider that for persons with disabilities they could be determined as “integrated” only in the most exceptional circumstances. We implore CMS to recognize that participation of these settings in HCBS programs will stunt the development of new or innovative infrastructure to meet the residential and support needs of current and future generations of persons with disabilities. Individuals with disabilities often have no truly integrated setting available to them, and the rule will perpetuate this unjust reality if, for example, cheap diagnosis-specific housing in remote areas remains a viable infrastructure option.

We also make the following recommendations:

- That housing should not be conditioned upon acceptance of services. For a setting to be community-based, the owner or operator of the setting cannot evict a person because he or she refused to accept a particular service.
- That board and care homes for persons with disabilities should be added to the list of prohibited settings in §§ 441.530(a)(2) and 441.656(a)(2).

#### *Exception for aging settings meeting special criteria*

Although we have recommended that CMS strictly guard the spirit of integrated settings as a general policy, we consider that CMS should develop a specific and limited exception for special aging settings (SAS) which meet special criteria of demonstrated value to the aging community. For example, certain assisted living facilities, continuing care retirement communities, or Section 202 housing may be acceptable places for older adults to receive HCBS. We believe the interactions between the aging community and SAS are simply too different to be governed by the same general framework we have recommended above. To be clear, we are not suggesting a broad exception for *all* entities self-identifying or designated with a particular moniker such as SAS, ALF, or CCRC. Instead, we recommend an exception for *some* such entities, as applied to older adults, which meet the requirements of the regulation at §§ 441.656(a)(1), (a)(2)(ii), (a)(2)(iii), and (a)(2)(iv), and also meet the special criteria (described below) which make these SAS valuable.

Although the aging community has vast commonalities with the disability community, there is greater precedent and greater demand within the aging community to live in population-specific and/or campus-like settings, and more potential disruption if these settings are completely excluded. More importantly, we believe that while individuals with nearly every functional status are present in both groups, they are present in very

different proportions. The aging population has certain functional status and prognosis trends, and related preferences, which are near universal in that population, while they are only sporadically present in the diverse disability community:

- The aging HCBS population includes many individuals with a very predictable and declining long-term prognosis in terms of health and functional status, based on the universal and predictable process of aging.
- At the same time, the aging HCBS population includes many individuals who have short-term and/or repeated fluctuations in level of care need; these fluctuations may have quick-onsets requiring fast transitions and may require short to middle-term shifts in setting.
- The aging population also has many individuals with significant health needs, in addition to functional needs, and cognitive impairments who cannot practically live safely in a home environment or maximize their function there.

Well-designed SAS settings, while not technically integrated under the general definition we have recommended (and thus not appropriate for persons with disabilities generally), can be beneficial to older adults by addressing the prevailing population needs described above if they meet special criteria:

- SAS can allow older adults to age in place over many years by having multiple level of care settings within one complex.
- SAS can address rapid changes or declines and short term level of care transitions with setting-specific flexibility.
- SAS can provide a safe setting for older adults, such as those with advanced dementia, who do not feel capable of maintaining a residence, can only achieve maximum function in a supported setting, and/or would otherwise be forced into institutional settings.

We believe that SAS, by offering the benefits of the above criteria, offer older adults a stable and valuable setting option in spite of the institutional traits of the settings. We therefore recommend that CMS develop an exception to the general framework for integrated settings to allow inclusion of SAS for aging populations, under certain circumstances. Specifically, with respect to older adults, we recommend some allowance for exceptions to the general presumptions concerning physical attributes of setting, size, diagnosis/disability specific settings, and housing conditioned upon acceptance of services, if the setting can show that it clearly meets one of the special criteria mentioned above. However, this will require CMS to develop some standards to evaluate whether a SAS is truly providing an experience that is non-institutional. We would urge CMS to require such settings to develop a publicly available community integration plan and document compliance with it, including compilation of complaints and comments filed by individuals related to community integration or the plan. Of critical importance is that the SAS define community integration to refer to the greater community, and offer residents the opportunity to integrate with a community that is broad than the resident population.

### *CMS enforcement of integrated setting standards*

Some states have a checkered history of complicity in the unnecessary institutionalization of older adults and persons with disabilities. We therefore believe that if CMS intends to allow states to certify which settings are integrated, and enforce the framework of this regulation (and in particular, adjudicate “rebuttable presumptions”), then CMS must take an active role in monitoring state determinations and policy enforcement. States face a combination of economic, political and governance pressures which make them susceptible to powerful forces that represent institutional care and/or have a vested interest in a status quo of institutional infrastructure. We recommend, therefore, that the regulation include robust provisions describing how state standards and processes will be developed by states, approved by CMS (critical standards, such as those used to evaluate exceptions to the rebuttable presumption, should be included in state plans and subject to CMS approval), and reported to CMS and publicly. Furthermore, the regulation must specify how CMS will act upon reported information and independently monitor to enforce the requirements of this regulation. We recommend that CMS’ monitoring of states include random sampling to verify state compliance with requirements around integrated settings.

#### **§ 441.530(a)(1)(ii)**

This paragraph does not address settings characteristics and perhaps belongs in the requirements for the individual service plan in §441.665. If left in this section, the language should relate more clearly to a facility-wide characteristic, such as “All residents have selected this setting from a meaningful choice of alternatives, including the most integrated setting appropriate for each resident.” The regulation should clarify that the fact an individual has chosen a setting does not in and of itself confer “integrated” status on the setting.

#### **§ 441.530(a)(1)(iii)**

NHeLP recommends CMS remove the term “essential,” as it could be read by a facility or others to limit the scope of personal rights referenced by the regulation.

#### **§ 441.530(a)(1)(iv)**

NHeLP understands the term “optimized” in this provision to refer to optimizing an *individual’s* autonomy taking into account the individual’s capacity. We would support such an interpretation. However, we are concerned the term could also refer to optimizing the *institution’s* promotion of autonomy, and we would not support such an interpretation. We suggest altering the term to read “optimized for the individual...”

#### **§ 441.530(a)(1)(v)**

The word “facilitated” establishes a weak standard and should be replaced with “maximized.”

### **§ 441.530(a)(1)(vi)**

NHeLP recommends that the service plan exception in this provision is overly broad in as much as it allows exceptions to §§ 441.530(a)(1)(vi)(A), (B)(2), (B)(3), (D), and (E).

Furthermore, while we recognize that individual safety may sometimes be a justifiable basis to limit individual rights, this exception threatens to make the rule meaningless; safety is such a broad and subjective concept that it can be used to shield almost any encroachment on rights. We urge CMS to develop a narrower framework for this exception and explicitly prohibit institutions using criteria linking limitations on rights to specific diagnoses or demographic factors. Limits on autonomy must be supported and based only on the individual’s documentable needs.

We note the term “another” in § 441.530(a)(1)(vi) appears to be extraneous (and does not appear in § 441.656(a)(1)(vi)).

We note that § 441.530(a)(2)(iv) includes the term “providing long-term care services” while § 441.656(a)(2)(iv) does not include the term. We do not believe it was CMS’ intent to exclude acute hospital settings from the prohibited list, so we recommend using the latter language at both cites.

### **§ 441.650—Basis and Purpose**

NHeLP recommends that CMS delete the language “with disabilities or individuals who are elderly.” While we understand that the statutory title created in 2005 for § 1915(i) included reference to “elderly and disabled individuals,” this language is merely a title which is not given effect in the statute itself and which is very harmful to the function of § 1915(i) as amended by the ACA. Eligibility for State plan HCBS is not limited to “elderly and disabled individuals,” and instead has always been available broadly to “individuals eligible for medical assistance under the State plan.” § 1915(i)(1). CMS restates this fact in the preamble to the proposed regulations: “To be eligible for the State plan HCBS benefit, an individual must be included in an eligibility group that is contained in the State plan.” 77 Fed. Reg. 26377. In accord, CMS specifically recognizes that children may be eligible: “Children included in eligibility groups under the State plan may meet the needs-based criteria and qualify for benefits under the State plan HCBS benefit.” *Id.*

Also, we note that the term “disability” already has numerous different meanings. Using this term in a potentially limiting way could be confusing and unfair to beneficiaries.

### **§ 441.656—State plan home and community-based services under the Act**



For comments to § 441.656(a), see our comments to the language in § 441.530.

We assume this provision in subparts (b) and afterwards to be listing requirements for the § 1915(i) option, but the regulation does not state this is the purpose of the list. This should be clarified.

We also believe there are two drafting errors the CMS should correct:

- Paragraph (d) references “(b)(2),” which doesn’t exist. We believe it should refer to (e)(2).
- Paragraph (e)(2)(ii) references “§ 440.182(b)” and we believe it should reference § 440.182(c).

### **§ 441.659—Needs-based criteria and evaluation.**

NHeLP strongly recommends that CMS develop clear transparency requirements for states implementing needs-based criteria. CMS must require states to make publically available, including by posting on a website, all of the needs-based criteria implemented for state plan HCBS eligibility. States should also be required to follow a clearly established process, including stakeholder input and public notice and comment, when it generally modifies its needs-based criteria. (Modifications due to exceeding projections are discussed separately, below). NHeLP urges CMS to implement these and other requirements to end the practice of some states which use unpublished HCBS criteria or modifications to such criteria to control enrollment and utilization in an arbitrary and discretionary manner.

NHeLP commends CMS for implementing in § 441.659(b) the § 1915(i) requirement to maintain a lower level of stringency for state plan HCBS eligibility than HCBS waiver eligibility. NHeLP also commends the specific requirement that that needs based criteria for specific services must not limit access in a manner that is “unreasonable.”

However, NHeLP is concerned that the stringency requirement will lead to states raising their institutional eligibility standards, leading to HCBS waiver disenrollments. While we appreciate that CMS has offered states FFP if they *choose* to grandfather in current enrollees when they tighten eligibility standards, individuals in states that do not grandfather may lose eligibility for Medicaid, access to Medicaid HCBS services entirely or in part, or access to Medicaid HCBS service providers which they have existing relationships with. We recommend that CMS specifically require:

- States must grandfather (in an HCBS waiver) individuals who would lose Medicaid eligibility due to “stringency” adjustments.
- For individuals who will maintain Medicaid eligibility, states may grandfather (in an HCBS waiver) them, or otherwise must ensure that their HCBS waiver services will be covered under the state plan option including access to their current providers.

We urge CMS to consider developing standards to protect current enrollees, and place the burden on states to develop clear and public transition plans when they modify eligibility standards.

NHeLP recommends that CMS delete the provision at § 441.659(c)(4)(ii). This provision allows modified standards to be applied to individuals who have any lapse in their Medicaid or HCBS eligibility; the HCBS population has predictable fluctuations in status and therefore the grandfathering provision should be flexible enough to protect individuals who go through short-term transitions.

NHeLP acknowledges the statutory requirement to allow states to modify needs-based criteria without obtaining prior approval from CMS when their enrollment projections have been exceeded. We believe this policy, in practice, will reduce transparency and harm beneficiaries, and we commend CMS for reiterating the statutory requirement for 60 days advance notice. We urge CMS to be more prescriptive about the public notice requirement, to include posting on a website and specific notice provided to MCACs and other state stakeholder groups. Additionally, we urge CMS to develop some standards around state enrollment “projections” – states will have an incentive to make low projections and thus provide themselves with maximum discretion to modify eligibility standards. (These standards could also be included at § 441.677(a)(1)(i), as we have noted in that section.)

While we understand that, after projections have been exceeded, a state might raise the state plan criteria and thereby necessitate making more stringent institutional LOC criteria, we urge CMS to implement the approach described in the bullets above to mitigate the harm to current HCBS waiver enrollees.

We commend CMS for implementing at § 441.659(d) the statutory requirement for independent evaluations. We recommend that CMS define the term “independent” in the regulation.

We commend the inclusion of a requirement at (d)(3) to consult with the individual, but recommend this be strengthened to include a more central role for the individual, including for example consultation with providers, social service staff, or others identified by the individual (as CMS has proposed in § 441.662(a)(2)).

We further recommend that, when assessing individual’s support needs per (d)(4), informal supports arranged by the individual not be considered unless the individual explicitly chooses to include them. (See also our recommendation at § 441.665(b)(5) below). For example, an individual who is without services may be relying on a neighbor to provide emergency attendant care. However, there may be many reasons why this care is not satisfactory; the neighbor may actually lack the capacity to provide all needed care (such as lifting), the neighbor may be overextending themselves and neglecting their own familial or employment responsibilities to provide the care, or there

may be privacy interests of the individual which are compromised. People in desperate need of services often rely on hasty informal arrangements to bridge gaps in care, and these emergency measures should not be deemed to be adequate supports.

We note the following drafting errors:

- Paragraph (b)(2) references paragraph (c)(7) in error. We believe the correct reference is (c)(6).
- Paragraph (d) references §§ 441.656(a)(1) through (5) in error.
- Paragraph (d)(2) references §§ 441.656(a)(1) through (3) and (b)(2) in error.

### **§ 441.662—Independent assessment.**

Please see our recommendations for § 441.659(d) above regarding additional requirements we suggest for independent assessments.

We recommend that the requirement to use a “person-centered process” in § 441.662(a) cross reference § 441.665. We suggest the term “, and meeting the requirements of § 441.665” be added to the end of § 441.662(a).

NHeLP recommends that CMS state clearly in the preamble to the final regulations that there is no particular ADL requirement for services or for a particular level of services. We believe the intent of § 1915(i)(1)(F)(i) was to make ADL function a required component of HCBS state plan services assessments, without any requirement for a particular outcome as a threshold for services. We agree with such a policy and note that it is supported by the language in the statute requiring an “evaluation” of ADL inability, as opposed to (for example) a “determination.” Therefore, we believe that no individual can be denied access to services simply because she fails to demonstrate inability or need for significant assistance to perform two or more ADLs. There is likely to be confusion on this point because the statutory language mentions two ADLs, and states may be prone to erroneously bar access to services based solely on ADL tests. We recommend that CMS clarify in the preamble that while ADL review is a required element of the assessment, the result of the ADL review cannot be a litmus test for access to services.

NHeLP recommends that at § 441.662(a)(4) (or elsewhere) CMS specifically require assessment for cognitive impairment, to be conducted by properly trained staff.

NHeLP commends the inclusion of a caregiver assessment at § 441.662(a)(4), which should help identify needs in the individuals informal support network and connect caregivers to needed supports, such as respite, training, and other assistance.

The proposed regulations, at § 441.659(a), offer that states *may* establish service-specific eligibility criteria. We believe the drafting of § 441.662(a)(5) confuses this point in that it implies that criteria must be in place for each service. (It also implies that an

individual could not require any service). We suggest moving the term “(if any)” to after the word “criteria,” and editing it to “(if any have been established)”.

We recommend that in § 441.662(a)(6) that CMS create a stronger regulation to promote self-direction of services. We recommend the term “any information” be modified to “notice, all information, and any supports.”

We believe that paragraph (a)(8) is too broad in as much as it prohibits access to services which would otherwise be available through other Federal programs. Such a prohibition should not be a part of the regulation unless:

1. CMS or the state provides assistance to access the service through the other Federal program, *and*
2. There is an exception for circumstances where an individual demonstrates a good-faith effort to access the services through the alternative program but is unable to do so.

We recommend that § 441.662(b), which details reassessments, be expanded to require reassessment “at the request of requested the individual,” as is similarly provided for in the regulation at § 441.665(c).

#### **§ 441.665—Person-centered service plan.**

NHeLP strongly commends the numerous and important consumer protections for person-centered planning processes and plans that CMS has included in this provision. We urge CMS to maintain all of these consumer protections. We also recommend that CMS to add a requirement that “all residents have selected this setting from a meaningful choice of alternatives, including the most integrated setting appropriate for each resident.”

NHeLP recommends adding a requirement that this process “is physically, culturally, and linguistically accessible to the individual.”

NHeLP recommends that § 441.665(b)(7) specifically define understandable to include “translation into the individual’s preferred language.”

NHeLP commends the requirement at § 441.665(b)(5) that natural supports cannot supplant needed paid services. However, we believe the most critical element is not whether the services are provided voluntarily to the individual, but rather whether the individual prefers the voluntary services to paid services. The regulation should clarify that the services should be provided voluntarily only “at the individual’s preference.” NHeLP recommends that the regulation make clear that individuals eligible for a paid HCBS service should never be required or pressured to rely on any natural supports if they prefer the paid service. (See also our recommendation at § 441.659(d)(4) above).

NHeLP commends the provision at § 441.665(b)(11) including self-direction of services. We note that the reference to § 441.574 in this provision should be corrected to § 441.674. While the regulation includes reference to the requirements of §§ 441.674(b) through (d), we recommend the regulation also specifically require that the service plan include the supports offered in § 441.674(e) and the services of the independent advocate discussed as 77 Fed. Reg. 26373.

#### **§ 441.668—Provider Qualifications.**

NHeLP agrees that CMS should set default rules to protect consumers, including necessary safeguards and written standards for providers as provided under paragraph (a). We recommend that some minimum safeguards be developed and specified in the regulation, with state flexibility to develop additional standards. CMS should review the state standards for approval.

NHeLP firmly supports the use of default rules around provider qualifications to protect some of the vulnerable populations who will be assessed for and provided HCBS services. At the same time, however, NHeLP recommends that CMS make these provider qualifications default rules which can be waived through an informed and affirmative choice, with a signed statement, by consumers who are directing their own care. For example, an individual who is hiring their own attendants should be allowed (through an informed and affirmative decision, including a signed statement) to waive the default qualifications and hire the attendant of their choice. This structure of default rule and waiver would ensure adequate protections for the majority of the population while allowing sophisticated consumers maximum autonomy over directing their own care.

NHeLP commends the inclusion of conflict of interest standards in § 441.668(b). We urge CMS to continue to work to improve these standards, as it has been our experience that the eligibility, LOC, and service plan decisions for individuals often reflect interests or issues other than the true needs of individuals.

#### **§ 441.671—Definition of individual’s representative.**

We commend CMS for including a definition of “individual’s representative,” though we believe the definition needs to be modified.

The regulation should explicitly state that the default rule is that the individual’s representative is the person chosen by the individual to represent them. Conflicts of authority should be decided in favor of the individual’s choice, subject to certain very strict limits. This should be the first requirement of the provision and should be included in subparagraph (b). We recommend further that CMS narrow the language “by policy of

the State Medicaid Agency” which is far too broad and could eviscerate the intent of the provision.

We suggest that CMS may need to include language explaining how the default rules may differ with regard to children.

In subparagraph (c), we understand the “extent of decision-making” to reflect an effort to promote shared authority, where an individual might make some decisions and appoint a representative to make others. We commend such a policy and urge CMS to maintain it.

In subparagraph (c) CMS also allows states to refuse to accept a representative that does not act in the “best interest” of the individual. While we realize that there are certainly situations where this problem may arise, we caution CMS that “best interests” may be a highly subjective assessment, and we believe substantial deference should be established for the stated interests of the individual and the decisions of their chosen representative. We urge CMS to maintain the requirement for documenting evidence and place a heightened burden on state refusal based on “best interests.”

#### **§ 441.674—Self-directed services.**

NHeLP commends CMS for including specific rules to address self-direction.

We recommend that in subparagraph (a) CMS explain that individuals should be encouraged to retain authority over all functions (budgeting, staffing, etc.), but that individuals could choose to only retain authority over specific functions. We also recommend that CMS add the term “, but not limited to,” after the term “including.”

We recommend that subparagraph (b) include a reference to subparagraph (e) requiring self-direction supports to be included in the service plan (subparagraph (e) is cross-referenced in other subparagraphs, at (c)(2) and (d)(4)).

We recommend that subparagraph (c) include “training” as one of the employer authority functions.

We recommend that subparagraph (e) explicitly include the requirement suggested in the preamble (77 Fed. Reg. 26373, first column) for an “independent advocate.”

#### **§ 441.677—State plan HCBS administration: State responsibilities and quality improvement.**

In subparagraph (a)(1)(i), no details are provided about how states would “project” HCBS enrollment. This is a critical calculation because states might have an incentive to understate projections to gain the discretion associated with over-enrollment.

NHeLP commends the inclusion of § 441.677(a)(1)(ii)(C) prohibiting the state from limiting access to HCBS based on income, cost, or location.

We commend the inclusion of authority in subparagraph (a)(2) to allow presumptive payment for HCBS evaluations and assessments, and the provision to allow FFP in the cases where presumptive payment was made based on good faith.

NHeLP recommends that the Periods of Approval requirement at § 441.677(a)(2)(vi) specifically include the statutory renewal requirement at § 1915(i)(7)(c)(ii) to meet “the State’s objectives with respect to quality improvement and beneficiary outcomes.”

NHeLP recommends that CMS require that states make publically available targeting, phase-in, and quality improvement plans, including by posting on public websites.

We would like to note the following drafting error:

- Paragraph (a)(1)(ii)(B) cross-references §441.656(b)(2), and this reference should be changed to §441.656(e)(2)

## **Conclusion**

In summary, we believe CMS has proposed strong regulations, but we request that CMS consider our recommendations to improve state plan services and integrated settings for vulnerable individuals. If you have questions about these comments, please contact Leonardo Cuello at (202) 289-7661 or [cuello@healthlaw.org](mailto:cuello@healthlaw.org). Thank you for consideration of our comments.

Sincerely,



Emily Spitzer,  
Executive Director