February 26, 2014

Centers for Medicare & Medicaid Services

7500 Security Boulevard

Baltimore, Maryland 21244-1850

Sent via email to: hcbs@cms.hhs.gov

# Re: OPRA Request for Subregulatory Guidance on “Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers” Final Rule

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Ohio Provider Resource Association is a statewide association of providers who serve individuals with intellectual and developmental disabilities. We respectfully request that CMS respond to the following questions. Further, that CMS consider these comments and questions in preparing subregulatory guidance for “Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers” final rule.

**Provider Controlled or Owned**

1. **Clarity regarding provider controlled or owned** - If a provider is providing HCBS services to all individuals in an unlicensed setting in a property owned and leased by a third party (landlord), is this setting considered provider owned or controlled? In the regulations, CMS refers to provider owned or controlled as also ‘operated.’ If the provider provides HCBS to the individuals in this type of home, but they are not the landlord, are they the operator? If so, this will create issues as there would then be potentially two leases or residency agreements between the residents and two separate entities (the provider and the landlord). Please provide clarification.

 **Choice of Provider for Residential/Supports**

1. “**Services inherent in the Setting**”- In the CMS comments you reference provider owned settings, “where the provision of services in inherent in the setting.” Can you provide additional guidance about this issue of services inherent in the setting?
2. **Service provision by others in a provider controlled setting** –For this question, please assume that the qualities of home and community based services are satisfied and the individuals have made an informed decision. In a provider owned setting that is licensed under state law to provide both room and board and services to 4 or 6 people, please clarify whether the consumer has a right to select a different provider to come into the licensed home over the objections of the licensed provider.

If individuals have this choice, this will cause concerns about security of other resident personal health information and medications, all of which today are the responsibility of the provider who owns or controls the facility/setting. Please provide clarity.

1. **Choice with a requirement to “share” support services**? - Consider the situation where services and housing are completely separated, provided by two totally independent, unrelated organizations. Also assume two individuals live in a house or apartment, and both are served with home and community based waiver services. Is there anything in CMS’s regulations that entitles the two individuals to choose different providers; i.e. do they each have freedom to choice, or can the state put parameters on the choice, to assure economical provision of services? For example, if both need assistance getting up and off to work, it would be more economical that they both use one provider, rather than two. Can they be required to “share” a provider?

**Housing provided separately from the Waiver Service/Support Provider**

1. Where a housing corporation owns the housing (not the provider), will a lease or some form of tenant agreement be required, as is the case for provider owned and controlled environments?

**Home and Community Characteristics and Services**

1. **Visitors** –Can residents come together and decide on what they want as far as visitation? Can the residents come together and all agree that there should be no visitors after a certain hour of the day?
2. **Visitors and a Lease** - Can a lease or residency agreement dictate that visitors are only allowed a certain time of the day? Or that prior notice must be given if visitors will be arriving at certain hours of the night, or if there is an unusually large number of visitors expected? What if a lease contains visiting hour requirements in it and the landlord is a 3rd party? Does it matter if the lease is with the provider or a 3rd party in this case?
3. **For heightened scrutiny**, how will questions about settings be decided by CMS for those providers who have questions? Will providers have to come to the state and then the state will send them to CMS? May providers send their questions to CMS for a decision? What if the state will not send the questions on to CMS? What if there is a disagreement between the state and CMS? Will CMS’ opinion prevail? Will CMS require states to have an appeal process or due process?
4. **Food** – How do we handle special diets or food related concerns? Some issues are addressed in a behavior support plan, but most do not need that level of intervention. Will addressing diet/food concerns in the plan be enough?
5. **Respite** – Can institutional respite be provided in an ICF/IID? If the answer is no, this will eliminate many respite options for individuals with DD for short term stays. While CMS’s comments in the regulations suggest that institutional respite will be allowed, please clarify this.

**Day Services and Supports**

1. **Integration in day services** – Can you please clarify the meaning of integration in day services? If a provider provides HCBS vocational services in the community - a coffee shop, for instance, where a majority of the customers buying coffee do not have a disability but a majority of the individuals who work in the coffee shop have a disability - is this integration? Or must the percentage of individuals **working** be at least 50/50 with a disability/not having a disability? If so, this seems like it would take away opportunities for individuals with disabilities, rather than enhance opportunities to work in the community. Can CMS please provide a clear definition of integrated community employment?

a. Also, can you please clarify whether the type of disability of the individuals working matters? For instance, there are vocational service programs that serve individuals with developmental disabilities and also serve those individuals with visual impairments. Is this an integrated setting?

b. Is CMS saying that a physical location itself may be isolating even if the type of individuals receiving services includes individuals with and without disabilities?

c. Is the physical location of a vocational program isolating even if the program’s focus is on vocational training and job placement in the community for individuals with developmental disabilities?

d. Please provide guidance on CMS’s expectations for an expected time per day/week/month an individual would be expected to be outside of the location? For example, with a 5 hours per day program, will participants be expected to be out in the community 50% of the time?

e. If an individual has no willingness to gain integrated community employment, is it expected that that individual will be served in an integrated community setting, or in an integrated setting for a certain percentage of the time?

f. How will HCBS services be provided to individuals who refuse to participate in an integrated setting? Will there be an allowable tolerance for a small percentage of these people, or of their time in the community?

g. Do enclaves and/or work crews that do not include people without disabilities, but work in the community with people without disabilities, meet the criteria for an HCBS service?

1. **Additional Guidance** - CMS has indicated there will be additional guidance coming on how the HCBS regulations apply to non-residential programs. In light of the different terms that are used, will CMS provide some ‘definition’ to distinguish between unpaid day programs, sheltered settings and training programs based in community?
2. **Day Services and Conflict of Interest** - Will it be allowed to have individuals on a waiver, who receive targeted case management from the same entity from which they receive HCBS waiver day services? Will CMS discriminate between geographic areas where there is no other HCBS waiver day service available and geographic areas where there are alternative HCBS waiver day services by providers who do not provide targeted case management?
3. **Day Services in Rural areas and Integration** – In a rural area, there are few options for day services. The “integrated” setting does not accept all individuals, for example, those with incontinence issues, behavioral challenges or those receiving nutrition via tube.
	1. If the IDD day services are available to anyone who is interested, not just those who receive HCBS services, but no one without an HCBS waiver requests services, will this meet the requirements for home and community based services?
	2. Can you provide more general guidance about how rural providers will be treated because our geography can already be unintentionally “isolating?” Can you please address this for transportation as well.
	3. Do we have to leave spaces open for non-HCBS individuals even if there is no demand from that population?
	4. Will rural providers be able to meet the standards if they demonstrate a good faith effort? If rural providers are sanctioned, this will limit access to services for individuals with disabilities.
	5. Some transportation providers use vehicles (e.g.: the “short yellow busses”) that clearly identify their passengers as individuals with a disability. Please provide clarity as to whether or not this is considered a community-based service. Will it change CMS’s interpretation of this service being considered a community-based service, if these transportation providers also offer their services to individuals without disabilities?
4. **Person-centered planning**
5. Since the regulations require informed consent, what if the provider does not believe that the individual can give informed consent because they are incompetent. Will the state be required to provide access to guardian services for those who are incompetent? Will all of these individuals need to be adjudicated incompetent, or will an assessment suffice? Can you please clarify the obligations of the parties in this instance?
6. Can you please clarify who is an independent assessor? Is the independent assessor subject to the same conflict of interest prohibition as the people involved in the person-centered planning?
7. Can you please clarify how conflicts of interest will be decided upon for those entities that are targeted case management providers and also HCBS providers?
8. Can an individual chose not to include their assigned targeted case manager in their person-centered planning, because the case manager is a provider of HCBS services? Can the individual choose another targeted case manager? Can the individual choose another targeted case management entity?
9. What does ‘timely’ mean? Does this mean that the provider and family are given adequate time to review and absorb the information contained in the plan (plans can be very lengthy) so that the parties understand the information in order to make informed decisions?
10. Many times, the targeted case managers will choose or match a number of individuals to live together and then the individuals choose the provider. If individuals each have a choice of provider, how will this work with the HCBS system that counts on the sharing of services? Please clarify.
11. In the person-centered plan, what is CMS envisioning in documenting alternative settings considered by the individual?
12. **Role of Provider in Person-Centered Plan** - Consider the situation where there is a licensed provider, who owns the home and provides support services to eight individuals through an HCBS waiver. Since this setting in Ohio is one that requires licensure, and imposes a variety of responsibilities on the provider, we are concerned about a situation where we, as the provider may not be involved or consulted in developing the ISP; not due to the preferences of the individuals we serve. Can you provide some additional guidance regarding the provider’s role in the ISP process, if the consumer does not object to our participation? Is there any circumstance where it is acceptable to CMS that inspite of no objection from the individual, the HCBS provider chosen by the individual is not fully included in the person-centered planning process?
13. **Children receiving HCBS** - How do the regulations relate to children receiving HCBS? Are children allowed visitors at all hours? Is it purely up to the guardian? Please provide additional guidance as there are many children receiving HCBS and these regulations seem to contemplate only adults receiving HCBS.
14. **No Harm, No Dignity** – How will CMS accommodate the “dignity of risk” for individuals with disabilities? Providers will do their best to not harm anyone to whom they are providing HCBS services. Yet, sometimes, the individual chooses to participate in activities that may be harmful to them (e.g.: driving, hiking, attending a baseball game, having a social media account, to name a few). People without a disability and who engage in these same activities assume a certain level of risk inherent in participation in the activity. Will CMS deny payment for HCBS services that assist the individual to participate in their community, in these activities that may cause harm to that person? Please provide guidance on this matter.
15. **Health and Safety** – Other times and in the best interest of the individual with disabilities, staff intervenes according to the service plan and the individual gets bruised or scratched. Will these HCBS services be disallowed? Will these HCBS services be disallowed retrospectively?
16. **Impact on Direct Care Staff, Quality and Rates** – If a state decides to combine target waiver groups, will the state be permitted to maintain the previously approved waiver reimbursement methodologies and waiver rates for each of the target waiver groups? Given the direct care staff shortage that exists today, the increased projected demand for services and direct care staff and the potential impact on quality, any reductions in waiver rates will likely have negative consequences.
17. **Technology-Enabled Supports** – OPRA supports individuals with disabilities having access to technology to enable them to gain participate in their community. Without technology, individuals with disabilities are simply not able to fully participate in their community. We appreciate CMS not wanting to limit the applicability of technology where it may be helpful and we look forward to this guidance from CMS. Will CMS also provide guidance on connectivity (for example broadband internet and cell phone) that is necessary for technology-enabled supports to work?

OPRA is available to assist CMS in the implementation of the new regulations. Please contact Mark Davis at 614-224-6772 with any questions or requests for further information. Thank you for your consideration.